

An Interpretative Phenomenological Analysis of Music Therapy Clinical Supervision Process

By
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Abstract

The aim of this Interpretative Phenomenological Analysis (IPA) study was to explore the process of clinical supervision for music therapy practicum from the perspective of the supervisor. Supervised clinical training in music therapy is required of student music therapists as part of their academic and clinical training prior to being qualified to take the board-certification exam. While music therapy supervision has been studied from different vantage points, the literature appears limited regarding the perspective of the supervisor in that process. With IPA as the methodology of the current study, the author conducted semi-structured interviews to investigate six supervisors' lived experiences and sense-making process of the process of clinical supervision. Twelve superordinate themes emerged as a result of data analysis, suggesting that supervisors' past experiences were impactful for their own growth in making effective decisions regarding supervisory models/approaches, techniques and formats. Supervisees' behavior, personality characteristics and clinical potential were factors that impacted the supervisor's perception of the supervisory process and supervisory relationship established on personal perspectives.

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Chapter 1: Introduction

Clinical Supervision

Supervision is a formal process of guidance, by a more experienced individual functioning as the supervisor, to promote productivity, performance and/or development (Clinical Supervision Guidelines, 2013). Large businesses, organizations and academic training programs apply supervision commonly for management and educational purposes. Within business and academic structures, the role of the supervisor includes the following tasks: providing guidance, affirming quality of service and evaluating efficiency. Supervisors in large business or organizations may also be responsible for administrative management and facilitation of communication between departments. However, clinical supervision relates to human services settings with real patients or clients. The aim of supervision within clinical training is to assist the supervisee in integrating knowledge from the classroom and field experiences in order to become a competent professional; clinical supervision also seeks to prevent harm during the learning process of the supervisee, allowing a professional to gauge and modify actions of the supervisee while still in training. Therefore, clinical supervision is commonly structured within particular healthcare fields, helping supervisees gain skills in such professions as nursing, speech-language pathology, counseling and music therapy.

Clinical supervision is a requirement to meet guidelines and regulations established for developing a career in nursing. To become a nurse in the United States, the individual has to pass the National Council Licensure Exam (NCLEX-RN). The requirement for taking the NCLEX-RN includes completing an approved nursing educational program that follows specific guidelines and regulations that are established by the National Council of State Board of Nursing (2018). The American Association of College of Nursing (2008) provides a framework for establishing a baccalaureate nursing program, which includes expectations for coursework and

clinical experience. Clinical experience is critical in nursing training, preparing the trainee to provide care to “a variety of patients across the lifespan and across the continuum of care” (American Association of College of Nursing, 2008, p. 33). Although the required clinical training hours vary across nursing programs, the training itself is considered essential and mandatory for all curricula. According to the curriculum for a four-semester Bachelor of Science in Nursing (BSN) from The University of Kansas School of Nursing, students must have 678 hours of clinical and laboratory experience before graduation (The University of Kansas Medical Center, 2018). Students in the nursing program are required to rotate working in a variety of settings under the supervision of an experienced nurse or other qualified preceptor to develop a broad knowledge of different populations. While traditionally an apprenticeship model for developing therapeutic skills has been common, the use of clinical supervision has been transferred from psychoanalytic culture and applied to nursing education since 1925 (Day, 1925; White & Winstanley, 2014).

Nursing studies have supported clinical supervision as an essential process for trainees to facilitate development of clinical skills, professional identity and self-care (Bifarin & Stonehouse, 2017). However, such research has been limited primarily to the last two decades (Jones, 2006). Research relating to the effectiveness of different clinical supervision models in nursing — such as Proctor’s three function model (Bowles & Young, 1999; Proctor, 1986; Sheppard, Stacey, & Aubeeluck, 2017) and Heron’s intervention analysis framework model (Sloan & Watson, 2001) — has been explored in different settings. Brunero and Stein-Parbury (2008) conducted an evidence-based literature review to synthesize studies that evaluated the effectiveness of clinical supervision in nursing. Researchers categorized 32 nursing studies according to Proctor’s three function model: professional accountability, skills and knowledge development and colleague/social support. In addition, the researchers examined what techniques

addressed the needs of the supervisees within each of these studies. Although researchers have investigated clinical supervision techniques, models and formats applied to a variety of settings, more studies targeting the supervisory process in nursing were necessary to advance the efficiency of nursing education.

Similar to nursing education, individuals who wish to become speech-language pathologists in the United States must complete the training under clinical supervision to obtain the Certification Clinical Competence in Speech-Language Pathology (CCC-SLP) from the American Speech-Language Hearing Association (ASHA) (American Speech-Language-Hearing Association, 2018a). To apply for the CCC-SLP, the individual must have completed a masters, doctoral or other post-baccalaureate program that meets the standards of the academic institution approved by the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA). Under the current requirement for the CCC-SLP, at least 400 hours of supervised clinical experience (a minimum of 25 hours for observation and a minimum of 375 hours for direct contact with the client/patient) must be completed before submitting the application for CCC-SLP (American Speech-Language-Hearing Association, 2018b). According to the certification handbook of American Speech-Language-Hearing Association (2018a), an CCC-SLP applicant must complete a graduate level program that includes “academic coursework and supervised clinical experience sufficient in depth and breadth to achieve the specified knowledge and skills outcomes” (p. 8). The expected competencies of an CCC-SLP applicant graduating from a Speech Language Pathology (SLP) program include but are not limited to: (a) demonstrating related knowledge from the perspective of biological, neurological, acoustic, psychological, developmental, linguistic and cultural aspects within the scope of practice; (b) skills of prevention, assessment and intervention; (c) knowledge of the code of ethics; (d) knowledge of evidence-based practice; and (e) professionalism. Specifically,

supervisors who deliver clinical supervision to the trainees must have the CCC-SLP. An ASHA approved program is responsible for establishing a variety of supervised practicum which gives trainees experience working with patients with different diagnoses across the lifespan. During the supervisory process in speech-language pathology, sufficient amount of time for direct supervision, an appropriate format for supervision and effective supervision techniques must be provided based on the developmental level of the trainees (ASHA, 2018). Furthermore, supervisory models and techniques for SLP training were studied. Dowling (2001), Duddling et al. (2017) and Ostergren (2011) all discussed Anderson's model (1988), which was commonly used in SLP training. New models have also been proposed in order to accommodate for a variety of supervisory needs (Dudding & Justice, 2004; Geller, 2002).

Establishing a career in the counseling field requires supervised clinical experience for a masters or doctoral degree in counseling with state licensure. However, the requirement for applying for licensure and the scope of practice in counseling is different in each state. For example: the state of Kansas offers the Licensed Professional Counselor (LPC) and Licensed Clinical Professional Counselor (LCPC) designations, while the state of Texas only has the Licensed Professional Counselor designation, with a temporary and provisional format (Behavioral Sciences Regulatory Board, 2018 ; Texas health and human service, 2014). More precisely, an individual has to complete a masters level degree with practicum experience and pass the nationally standardized competency exam for the LPC in Kansas, while the LPCP not only requires licensure as an LPC but also 4000 hours of supervised clinical experience with an approval plan (Behavioral Sciences Regulatory Board, 2018). Accordingly, the importance of supervised clinical experience in counseling training is not to be refuted. Supervised clinical experience is considered a critical process of integrating knowledge while in direct contact with 'real' clients. Therefore, a masters level program meeting the standard of state boards usually

includes coursework abiding by the state licensure requirements, as well as mandatory clinical practicum for counseling students. As an example, the master's program in counseling at The University of Kansas provides a 9-month practicum experience during the second year of the curriculum. Students in this program are required to have at least 100 hours of clinical work with a variety of clientele under the supervision of a supervisor holding a credential in mental health counseling. Supervisees obtain weekly individual supervision, feedback provided for video/audio recordings of sessions in verbal or written form, as well as live individual or group supervision experiences (Department of Educational Psychology at University of Kansas, 2017). To facilitate growth and development of trainees, the application of clinical supervision has existed for over 120 years in the counseling profession for the novice therapist to begin the journey of becoming an independent and competent counselor (Bernard & Goodyear, 2014). Additionally, clinical supervision research and literature in counseling started to appear with the publication of The Counselor Education and Supervision journal in 1961 (Edwards, 2012). Different frameworks, models and techniques of clinical supervision in a variety of setting such as school, mental health facility or marriage counseling has been explored to provide more effective supervision.

In the music therapy profession, an individual may sit for the board certification exam to obtain the Music Therapist-Board Certified (MT-BC) credential for practicing music therapy in the United States. To be eligible to take this board certification exam, the individual must complete an approved bachelors or equivalency music therapy curriculum with a clinical training component through practicum and internship. Concurrent with academic coursework, individuals must complete at least 180 hours of pre-internship clinical experience before applying for an internship; eventually completing 1200 hours of clinical training inclusive of both pre-internship practicum and the clinical internship. A certain percentage of clinical hours must be facilitated

under the supervision of board-certified music therapists, before entry level therapists can independently practice music therapy in the field (American Music Therapy Association, 2018a).

During clinical training, student music therapists advance their musicianship, facilitation skills and therapeutic effectiveness to become competent music therapists. The intent of clinical supervision is to facilitate the generalization of academic knowledge into clinical practice. Thus, an academic institution approved by AMTA must provide the opportunity for supervisees to work with a variety of clientele to prepare this transition from the academic environment to the professional field. The framework of clinical supervision in music therapy may be adopted from other healthcare professions. In order to understand this process of clinical supervision and how to effectively facilitate the necessary development of supervisees as they enter the professional field, researchers in nursing, speech-language pathology, counseling and music therapy have examined models of clinical supervision, clinical supervision techniques and potential challenges inherent in clinical supervision.

Clinical supervision in music therapy plays an important role in clinical practicum training from the academic institution, internship and in the continued education of the board-certified music therapist, therefore, research in music therapy investigating the effectiveness of clinical supervision is critical. As a healthcare profession, music therapy shares similar characteristics in education and clinical training with other professions including nursing, SLP and counseling; therefore, the development of clinical supervision in music therapy has roots in supervisory theory from comparable experienced professions. The research and literature on clinical supervision in music therapy started to blossom with the establishment of three premiere music therapy journals, *Music Therapy*, *Journal of Music Therapy* and *Music Therapy Perspectives*.

The first article about clinical supervision in music therapy in the *Journal of Music Therapy* was published in 1973 by Samuel Southard, who discussed the process of student supervision (Southard, 1973). Later, Stephens (1984) conducted a study for *Music Therapy* investigating the interaction of verbal and musical elements during the process of group supervision and provided an example of a supervisory session. Around the same time as Stephens' (1984) publication on group supervision, Krout (1982) wrote an article for *Music Therapy Perspectives* presenting the model he established to train music therapy practicum students in school settings (Krout, 1982). Studies about the supervisory relationship, supervision issues, challenges and techniques in music therapy have since been examined (Edwards & Daveson, 2004; Lloyd, Richardson, Boyle, & Jackson, 2017; Ortiz, 2012; Salmon, 2013; Tanguay, 2008; Wheeler, 2002). Forinash (2001) edited *Music Therapy Supervision*, accumulating clinicians' and educators' experiences supervising in practicum, internship and professional settings. Forinash (2001) discussed different supervision approaches as based in various perspectives, including: a competency-based approach, a student-centered approach and incorporating creative art into supervision. Later, *Supervision of Music Therapy*, edited by Odell-Miller and Richards (2009), presented the history of music therapy supervision, challenges in the supervisory process and their own reflective thoughts from the perspective of supervisors in music therapy (Odell-Miller & Richards, 2009). While clinical supervision in music therapy has adopted frameworks, models and formats of clinical supervision from other healthcare professionals as a foundation, the complexity of music and diverse client populations have motivated researchers to further study clinical supervision processes (Dillard, 2006).

Nursing, SLP and music therapy have been developing their own clinical supervision models and techniques over time for the specific needs of each profession. However, the foundation of clinical supervision in these professions was often influenced by the counseling

field, due to its longer history practicing clinical supervision. Comparable to the development of different philosophies in psychotherapy, diverse models of clinical supervision were also grounded within different psychotherapy orientations. Some of the major psychotherapy orientations established within the counseling profession include psychoanalytic, humanistic, systemic and cognitive. In addition to the psychotherapy-based models, the developmental model in psychotherapy was also applied to clinical supervision in counseling. Bernard and Goodyear (2014) presented multiple developmental models that were established viewing supervisee's learning as a continuum, such as the Longanbill, Hardy and Delworth model (Loganbill, Hardy & Delworth, 1982), the integrated developmental model (Stoltenberg & McNeil, 2010) and the systemic cognitive-developmental model (Rigazio-DiGilio, Daniel & Ivey, 1997). The developmental model often categorized the supervisee's growth into different stages and suggested the supervisory techniques that a supervisor can implement to address the possible supervisory challenges in each stage. Furthermore, Bernard (1997) also established a discrimination model from the developmental perspective to focus on the educational element and the relationships within the supervisory process (Bernard, 1997; Bernard & Goodyear, 2014). Numerous models of clinical supervision in counseling have been exploring to fulfill the current needs of the profession. With grounding in clinical supervision models of counseling, clinical supervision in nursing, SLP and music therapy have intentionally modified frameworks to meet the needs of each individual's own professional identity as appropriate.

Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) has recently gathered attention in qualitative approaches to research in psychology. Phenomenology, hermeneutics and idiography are the three pillars that support the IPA process and are defined as the study of experience, the theory of interpretation and the commitment to the particular experience or individual,

respectively. Hence, IPA is known for its characteristics of exploring the lived experience of individuals and the process of expressing that experience from a targeted environment (Smith & Osborn, 2015b). The lens of the researcher in an IPA study is considered valuable, which contrasts the pursuit of objectivity deemed essential in some methodologies. To gather detailed, in-depth and rich descriptions of certain experiences, Smith, Flowers and Larkin (2009) recommended using semi-structured interviews, structured interviews or focus groups to collect data. The authors also noted the following for data analysis: identifying patterns and producing a narrative with researcher interpretation (Smith et al., 2009).

With its unique intention to focus on certain experiences, IPA was applied to research in the counseling field to study the process of clinical supervision. Carrola, DeMatthews, Shin and Corbin-Burdick (2016) conducted an IPA study to understand the process of supervisors adjusting their role in the correctional setting (Carrola et al., 2016). Nel and Fouche (2017) interviewed students about their experiences in clinical supervision in the applied psychology program and used data analyzed through IPA to identify themes indicating characteristics of effective supervision. McCandless and Eatough (2010) used semi-structured interviews to understand the process of how experienced supervisors facilitate the growth of supervisee's reflexive ability (McCandless & Eatough, 2010). While the studies of clinical supervision in counseling have adopted IPA to take advantage of its strength in investigating the experiences of clinical supervision, IPA research regarding clinical supervision in music therapy is limited.

Clinical supervision in music therapy is a complex process. Although the purpose of clinical supervision remains the same as other healthcare professions, the complexity of music and the diversity of potential clients provide experiences for the process of clinical supervision that may be unique to music therapy. Therefore, the aim of this IPA study was to explore the

process of clinical supervision for music therapy practicum from the perspective of the supervisor.

Chapter 2: Review of Literature

What is Supervision?

Definition of supervision. Supervision is “the action, process, or occupation of supervising,” which includes “critical watching and directing” (Supervision, 2018). Supervision can be categorized into administrative supervision and clinical supervision, with each serving different purposes and functions (Campbell, 2011). Administrative supervision considers the supervisee as an employee while clinical supervision sees the supervisee as a clinician (Kreider, 2014). Managing the operation of the program or facility and evaluating the performance of the supervisee are the foci of administrative supervision (Kreider, 2014; Tromski-Klingshirn & Davis, 2007). In contrast, clinical supervision primarily targets assisting the growth and development of the supervisee as well as the welfare of the client(s) served by the supervisee (Campbell, 2011; Kreider, 2014; Tromski-Klingshirn & Davis, 2007).

The Association for Dance Movement Psychotherapy UK (ADMP UK) identified three primary types of supervision: clinical supervision, line management supervision and academic supervision. Their definition of clinical supervision shares a similar purpose as that defined above: setting a safe stage for the supervisee to practice skills and develop knowledge under the guidance of a supervisor. Although the term line management supervision is not the same as that defined as administrative supervision by Kreider and Torimski-Klingshirn (2007), the functions of line management supervision are comparable to administrative supervision, which includes such tasks as solving a practical issue, coordinating the multidisciplinary team and managing a caseload. Additionally, the ADMP UK incorporates academic supervision as a support when a supervisee needs guidance for research or academic advisement (Association for Dance Movement Psychotherapy UK, 2013).

A supervisee in training may experience different types of supervision for different purposes and outcomes, such as clinical supervision, line management supervision and academic supervision as mentioned above. The current research study focuses specifically on clinical supervision. To further delineate differing types of and approaches to supervision, I begin by providing a general definition of clinical supervision; I then offer field-specific definitions of clinical supervision for the following professions: nursing, speech language pathology and audiology and counselling.

Definition of clinical supervision. Clinical supervision is a formal process of professional support that helps supervisees develop knowledge and gain competence (Barnett & Molzon, 2014; Falender & Shafranske, 2014; Levinge, 2002). The word clinical can be defined as either “relating to or conducted in a clinic involving direct observation and/or treatment of living patients” (Clinical, 2018). In other words, clinical supervision includes “direct contact with an actual client while under critical watching and directing of an activity or course of action” (Supervision, 2018). Clinical supervision can promote growth and therefore future success for students receiving clinical training. The American Speech-Language-Hearing Association (ASHA) recognizes clinical supervision as “part of their training and education process” (American Speech-Language-Hearing Association, 2018c). The role of the supervisor in clinical supervision of speech-language pathologists is not only a teacher teaching specific techniques, but also a mentor eliciting critical thinking; sometimes even a consultant giving advice (Council of Academic Programs in Communication Sciences and Disorders, 2013). Similarly, Bernard and Goodyear (2014) defined clinical supervision as:

an intervention provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession. This relationship is evaluative and hierarchical, extends over time and has

simultaneous purpose of enhancing the professional functioning of the more junior persons; monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a gatekeeper for the particular profession the supervisee seeks to enter. (p.9).

In contrast, the clinical supervision guidelines from the Alcohol and other Drugs and Community Managed Mental Health Sectors describes clinical supervision as a relationship; a “formal and disciplined working alliance” (Clinical Supervision Guidelines, 2013, para 1), differentiating such from the intervention described by Bernard and Goodyear (2014). Both definitions involve a more experienced clinician and less experienced clinician (supervisee) but not necessarily collaboratively working on the growth and the development of the supervisee. Accordingly, clinical supervision is a process of guiding and evaluating the novice to ensure quality service is delivered in the professional field.

With the focus on assuring quality service, clinical supervision serves multiple purposes. One of the primary purposes is to cultivate the development of supervisee’s autonomy referring to self-awareness, self-evaluating and problem solving (Dowling, 2001; Severinsson, 2001). In addition, clinical supervision in practicum and internship often requires assisting the transition from academic theory to clinical wisdom (Binnie, 2011). Clinical supervision also serves to protect the clients’ welfare of clients. In other words, the functions of clinical supervision are teaching and training of the supervisee, as well as monitoring of the therapist-client relationship (Campbell, 2011). Embedded in these functions is the exploration of job identity and ethics through important conversations between supervisor and supervisee (Severinsson, 2001).

The supervisor has responsibilities to both the supervisee and client. The competence of the supervisor has therefore been emphasized in an effort to provide the most effective supervision practice for the supervisee (Falender & Shafranske, 2014). Supervisors often apply

models and strategies from their own experiences as a supervisee instead of obtaining specific training in clinical supervision (Campbell, 2011). However, a competent supervisor is expected to be acquainted with and have knowledge of models, methods and strategies of clinical supervision which allows supervisors to customize more appropriate supervision for the individual supervisee (Campbell, 2011).

The supervisory relationship is often mentioned when exploring the topic of clinical supervision in health care fields such as nursing, speech-language pathology, counseling and music therapy. Each of these fields has broadly utilized clinical supervision in practicum, internship and clinical practice for enhancing professional growth. An effective supervisory relationship is foundational to achieving the goals of clinical supervision (Bernard & Goodyear, 2014; Falender & Shafranske, 2004). In the supervisory relationship, supervisor and supervisee establish a working alliance to decide goals, complete tasks and build rapport (Bordin, 1983). The supervisor and supervisee are expected to be open, actively and collaboratively participating in the process. (Campbell, 2011; Falender & Shafranske, 2012). ASHA (2018) described the supervisory relationship as “collegial” in the *Scope of Practice in Speech-Language Pathology* (para.5). Sloan (2005) recognizes the importance of the supervisory relationship in nursing practice and proposes an agreement checklist to facilitate the establishment of an effective supervisory relationship. In order to provide effective clinical supervision to better support the supervisee applying acquired knowledge into clinical practice, researchers have placed significant attention on this process.

Although clinical supervision in health care professional fields may use similar models and subsequent strategies and techniques, differences in application may still be noticeable due to the unique characteristics of each profession. Given those unique characteristics, supervisee

and client needs are inherently varied. Adaptations and new techniques are established in order to fulfill the current requirements of each individual profession.

Clinical supervision in nursing. The importance of clinical supervision in nursing has been recognized in nursing education to promote professionalism and quality of service (Häggman-Laitila, Elina, Riitta, Kirsi, & Leena, 2007; Teixeira, Carvalho, & Cruz, 2016). Although the requirements of clinical experience for each program are different, most of the core curriculum includes clinical experience in a supervised setting. In particular, there is a novice or new nurse as a supervisee and an experienced nurse acting as a supervisor (Jones, 2006b). Butterworth (1992) considers clinical supervision an “exchange between practicing professionals” (p.12) that addresses various developmental goals of the supervisee. These goals include job identity, ethics, competencies and therapeutic skill in the particular setting of the supervisee, with opportunities to evaluate and reflect on their own practice with support from a supervisor (Severinsson, 2001; Winstanley & White, 2003). Based on requirements of different curricula, research activities and teamwork skills are occasionally addressed in clinical supervision as well (Häggman-Laitila et al., 2007).

For the purpose of improving clinical practice, the supervisee commonly engages in reflection about patient interaction with their patients during supervision (Brunero & Stein-Parbury, 2008; Jones, 2006). Three core concepts in nursing supervision include confirmation, meaning and self-awareness. Through confirmation, the supervisee is invited to dialogue with the supervisor to gain insight regarding supervisee’s experience in the field. Moreover, the supervisor helps the supervisee identify the meaning and value for caring for clients while dealing with burnout and stress from the work environment. Eventually, supervision provides the opportunity for supervisee to establish self-awareness (Severinsson, 2001) and by gaining self-awareness skills, the supervisee is able to notice and identify mistakes in their own skills.

Clinical supervision in speech-language pathology and audiology therapy. Clinical supervision in speech-language pathology (SLP) and audiology is mandatory for students pursuing a degree in SLP or audiology as well as when obtaining national certification from the American Speech-Language-Hearing Association (ASHA) (American Speech-Language-Hearing Association, 2005; Newman, 2005). Based on certification standards from ASHA (2014), individuals who are interested in being certified therapists must complete at least 400 hours of supervised clinical practice in different settings (American Speech-Language-Hearing Association, 2014). Although ASHA does not detail a specific number of hours of training for specific disorder categories or age spans, the practicum from each academic training program may require it leading to state licensure (Newman, 2005). To advance professionalism and provide an effective learning stage, the importance of clinical supervision in SLP has been recognized since the first establishment of clinical supervision guidelines by ASHA in 1985. These guidelines indicate the supervisory tasks and expected competencies (American Speech-Language-Hearing Association, 1985; Dudding, McCready, Nunez, & Procaccini, 2017).

In the SLP supervisory process, the primary task is teaching skills related to the supervisee's clinical practice. Therefore, instead of identifying the term clinical supervisor in the supervisory process, the term clinical educator is suggested by many professionals to reflect more accurately the role of clinical supervisor (American Speech-Language-Hearing Association, 2018c). Additionally, SLP clinical educators should acquire knowledge of supervision models in order to utilize the most effective style for facilitating supervisee's learning (Campbell, 2011).

Clinical supervision in counseling. Clinical supervision is required by the American Counseling Association (ACA) for all state licensures. Although the requirement of state licensure is slightly different for each state, an individual who is interested in becoming a

licensed counselor must complete at least 1000 hours of documented clinical experience under supervision. Face to face supervision with a qualified supervisor is also mandatory along with direct clinic contact (American Counseling Association, 2007). Since clinical supervision is deemed crucial for training of the licensed counselor, the definition of clinical supervision has been discussed by several individuals in the counseling field. Falender and Shafranske (2004) state that:

Supervision is a distinct professional activity in which education and training aimed at developing science-informed practice are facilitated through a collaborative interpersonal process. It involves observations, evaluation, feedback, the facilitation of supervisee self-assessment and the acquisition of knowledge and skills by instruction, modeling and mutual problem-solving. In addition, by building on the recognition of the strengths and talents of the supervisee, supervision encourages self-efficacy. Supervision ensures that (it) is conducted in a competent manner in which ethical standards, legal prescriptions and professional practices are used to promote and protect the welfare of the client, the professional and society at large” (p.3).

Similarly, according to the 2014 Code of Ethics approved by the ACA Governing Council, the process of clinical supervision is built on “theoretical and pedagogical foundation.” Clinical supervisors must have knowledge of the supervision model to “foster meaningful and respectful professional relationships and to maintain appropriate boundaries with supervisees...” (American Counseling Association, 2014, p. 12).

Supervisors need to adjust their role based on the emphasis of the supervisory process and the evolving relationship to provide the most effective supervision (Bradley & Ladany, 2001; Young, Lambie, Hutchinson, & Thurston-Dyer, 2011). One of the purposes for utilizing

clinical supervision is fostering supervisee's competence when practicing clinical skills in the field during the supervisory process. The supervisor serves a role similar to a teacher, delivering knowledge and clinical wisdom (Falender & Shafranske, 2012; Ronnestad & Skovholt, 1993). At the same time, supervision often brings up personal issues for the supervisee (Campbell, 2011), which leads the supervisory relationship to potentially share similarities with counseling. These similarities include considerations such as providing a non-threatening, accepting and understanding atmosphere (Patterson, 1964). Moreover, as the supervisee develops autonomy as a therapist, the supervisor may turn to a consultative role; such a transition allows the supervisee gains experience through more independent clinical opportunities (Bernard & Goodyear, 2014).

The focus of supervision can be categorized into intervention skills, conceptualization skill and personalization (Bernard, 1997; Bernard & Goodyear, 2014). Oftentimes, novice therapists strive to implement academic knowledge learned from the classroom into clinical practice; therefore, they ask for more structured guidance such as modeling from the supervisor during early stages to help develop intervention skills. As they establish intervention skills along with clinical experience, supervisees start to focus more on the client than themselves. They begin to build conceptualization and personalization skills. Conceptualization refers to the ability to acknowledge and understand specific issues related to the client. Client issues include possible causes of current clinical needs and the identification of potential interventions that are most helpful (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005). Personalization refers to the supervisee incorporating their personal style into therapy while also managing personal issues — such as countertransference — to maintain a healthy therapeutic relationship (Bernard & Goodyear, 2014).

The relationship between supervisor and supervisee is impacted by the developmental level of both supervisor and supervisee. The supervisory relationship is “a strong, working

alliance between the supervisor and supervisee grounded in open and honest communication, which is necessary for effective supervision to occur” (Falender & Shafranske, 2004; Young et al., 2011, p. 2). Similar to a counseling supervisory relationship, the following characteristics are required for a positive and effective supervisory relationship: empathetic understanding, openness to change, commitment, communication, genuineness and respect. Characteristics of the counseling relationship and supervisory relationship are comparable but slightly different. In a counseling relationship, the priority is the welfare of the client; while the purpose of the supervisory relationship is to support the growth of the supervisee while balancing protection for the client (American Counseling Association, 2014; Pearson, 2000).

Models of Clinical Supervision

Clinical supervision model provides a framework for the supervisor to facilitate supervisees’ growth in knowledge, skills and job identity. Below, the researcher discusses the clinical supervision models that are relatively common in nursing, speech-language pathology, and counseling. The counseling field has a longer history in practicing supervision, therefore, it has a variety of models grounded by different psychotherapy theories or foci. Nursing and speech-language pathology supervision models are often adopted or adapted from the counseling field.

Clinical supervision model in nursing. The model of supervision in nursing is derived from or influenced by supervision models in the counseling field. Proctor’s (1986) three-function model is one of the most popular models in nursing supervision and is widely applied for nursing education in various settings (Sloan & Watson, 2002; White & Winstanley, 2014; Winstanley & White, 2003). The three-function model includes elements that serve different purposes: normative, formative and restorative (Proctor, 1986). The normative element is the managerial task during the supervisory process, such as organization management and accountability. The

formative element is the educational task, which includes facilitating the growth of skills and knowledge. The restorative element describes a supportive approach to help the supervisee manage stress from the job (Bowles & Young, 1999; Proctor, 1986; Winstanley & White, 2003). Bowles and Young (1999) conducted a research study to evaluate the outcome of using Proctor's three-function model as the framework for supervision with results indicating participant benefit from all three functions of this supervision model. Specifically, although Proctor's (1986) three function model does not emphasize self-awareness, increases in self-awareness are identified as a benefit after receiving clinical supervision in nursing (Bowles & Young, 1999).

Furthermore, study results suggest participant concerns about connecting the gap between academic knowledge and clinical practice. Hall-Lord, Theander and Athlin (2013) and Baxter (2007) described the challenge of facilitating the supervisees' transition from theory to the actual practice as well as making the adjustment from academic culture to hospital culture. In order to prepare the nursing student for their future role, Hall-Lord et al. (2013) established a structured clinical supervision model for the bachelor level nursing degree. Baxter (2007) developed a model grounded on five caring behaviors: communication, collaboration, application, reflection and evaluation (CCARE) (Baxter, 2007; Hall-Lord et al., 2013). Both supervision models included the incorporating of existing theory into clinical practice. Besides focusing on connecting the gap between the academic and clinical culture, the CCARE model emphasized interactions between the preceptor, the clinical teacher, the patient and the nursing student in order to ensure that patients receive quality care either directly or indirectly. The interaction refers to the five caring behaviors, which not only advance nursing practice but also equip the nurse with the required competencies (Baxter, 2007). On the other hand, Hall-Lord et al. (2013) identified more specific goals for their clinical supervision model in the bachelor level nursing program: "supporting active research of knowledge, critical thinking and reflective learning,

supporting affective learning, supporting clinical nurse as preceptor role, facilitating assessment of students and assuring goal-oriented collaboration over time between the university and the clinical placements” (p. 507). With the aim of accomplishing these stated goals, the authors indicated four levels of supervision to meet the needs of the supervisee: (a) a triangle meeting between student, personal preceptor and clinical nursing lecturer is required to set an appropriate goal for the practicum; (b) supervisee needs to submit academic assignments based on the practicum placement; (c) supervisee needs to participate in a clinical seminar in a small group format held by nurse lecturer and personal preceptor; and (d) the supervisee was guaranteed individual and group supervision meetings with their supervisor.

In summary, researchers have described a widely-adopted model of supervision (Proctor, 1986) and two more recent models (Baxter, 2007; Hall-Lord et al., 2013) established especially for connecting theory to actual practice. With a focus on improving nursing education, models and approaches were developed based on the needs of the setting. Similarities and differences were observable among different nursing supervision models; however, the determined goal was always to provide quality care for the patient.

Clinical supervision model in speech-language pathology. Anderson’s model of supervision for speech-language pathology has been emphasized by ASHA and widely adopted for clinical supervision in SLP (Dowling, 2001; Dudding et al., 2017; Ostergren, 2011).

Anderson (1988) considers the development of the supervisee as a continuum process which can be categorized into evaluation-feedback, transition and self-supervisory stages. In the first stage, the supervisor provides structured guidance for supervisee’s clinical practice; in the second stage, the supervisor then works collaboratively with supervisee; finally, the supervisee self-evaluates clinical practice critically with support from the supervisor acting as a consultant. According to Anderson, the level of collaboration between supervisor and supervisee decreases

inversely with the development of the supervisee. During this stage of self-evaluation, instead of overlooking the supervisee, the supervisor provides consultative feedback as a peer. The goal of clinical supervision in SLP is preparing the supervisee to practice independently (Anderson, 1988). Because the SLP serves a variety of diagnoses and age spans, the development of autonomy with critical thinking and problem solving are essential.

In addition to addressing skill and technique acquisition, the SLP's education and supervisory process emphasizes human value and relationships (Prutting, 1985). Therefore, many current supervision approaches adopt reflective practice into the supervisory process (Dudding et al., 2017). Geller (2002) proposed a reflective model combining developmental, collaborative and reflective components. The goal of supervision is to foster supervisee's awareness regarding the "interpersonal dynamic" and the difference between self-and others such as "values, beliefs, culture and learning styles" (p. 6). During the supervisory process, supervisee is encouraged to concentrate on reflecting on the process and the relationship between self and client instead of focusing on techniques or procedures. Additionally, Dudding et al. (2017), mentioned the importance of flexibility in reflective practice, which refers to "the ability to make changes in behavior while engaged in the activity" (p. 8).

While technology has become more accessible for educational purposes, Dudding and Justice (2004) discuss the use of an e-supervision model to overcome the challenge of supervising students who are placed at off-campus practica. By using an e-supervision model, the supervisor is able to observe the session and give feedback after the session, which is somewhat comparable to a traditional format. Although e-supervision has a positive impact on decreasing the cost for travel, the initial investment for purchasing the necessary technology equipment is not to be ignored. Potential limitations of this model may include such factors as the inability of the supervisor to easily model or demonstrate techniques, challenge of observing

sessions in diverse clinical contexts and difficulty of detecting detailed verbal or non-verbal elements in the session due to the technology platform (Dudding & Justice, 2004).

Clinical supervision started to be recognized as an essential component of practice in SLP in 1985 (Dudding et al., 2017). The latest guidelines for clinical education and supervision from ASHA (2018) describe the following: clinical supervision models, expected knowledge and skills for a clinical educator and clinical supervision techniques.

Clinical supervision model in counseling. While numerous theories of psychotherapy and counseling continue to develop, models of clinical supervision in counseling concurrently evolve (Bernard & Goodyear, 2014). Although there are many clinical supervision models, there is no model perfect for all supervisees (Kaufman & Schwartz, 2004). The model of clinical supervision provides structure and guidance, with the supervisor having the responsibility to identify the most effective model based on the supervisee's level of development as well as the practice setting (Bernard & Goodyear, 2014; Campbell, 2011). The author has put forth a variety of clinical supervision models related to counseling, as linked to different theoretical frameworks. Based on the classification from Bernard and Goodyear (2014), a model of clinical supervision serves as an "organizational map." Each unique model can be categorized by the theory or theories that ground it. The authors note that some clinical supervision models are based in psychotherapy theory, others on developmental theory and others as based on process theory (Bernard & Goodyear, 2014). Accordingly, models of clinical supervision from other literature can be sorted by the classifications adapted from Bernard and Goodyear (2014).

Models grounded in psychotherapy theory. Psychotherapy theories provide a theoretical framework for clinical supervision that incorporates the clinical approaches and techniques inherent in that model. The aim of choosing a model grounded in psychotherapy theory is often to train the supervisee how to practice clinically within that specific model (Bernard &

Goodyear, 2014; Falender & Shafranske, 2004). Four clinical supervision models established in psychotherapy theory: psychodynamic, humanistic-relationship, cognitive-behavioral and systemic. Each will be described below.

Psychodynamic supervision model. Psychodynamic oriented supervision focused on only providing advice to the supervisee while also concentrating on the supervisee's subjective experience, personal reactions and clinical decision making (Falender & Shafranske, 2012). Frawley-O'Dea and Sarnat (2001) further discuss three dimensions that are foundational to the psychodynamic supervision model: the nature of the supervisor's authority in relationship to the supervisee, the supervisor's focus and the supervisor's primary mode of participation. The authority of supervisors is presented on a continuum. On one end supervisors objectively help supervisees discover what is "true" about the client and the appropriate intervention to use, while on the other end, supervisors consider themselves more of an "involved participant" but with significant experience (Frawley-O'Dea & Sarnat, 2001, p. 26). The supervisor's focus can be on the client, the supervisee or the supervisory relationship; and the participation of supervisor refers to the role of the supervisor in the supervisory relationship (Frawley-O'Dea & Sarnat, 2001). The psychodynamic supervision model suggests that the relationship between supervisor and supervisee potentially manifests a parallel process for the supervisee and their client, in other words, the supervisory relationship is often a reflection of the supervisee's experience with their client (Campbell, 2011; Kaufman & Schwartz, 2004; Pearson, 2000). Corresponding to psychodynamic therapy, the model of supervision based on psychodynamic theory focuses on transference, countertransference and defensive mechanisms while examining challenges in the supervisory process. For the purpose of facilitating the subjective reflection of supervisee's experiences with their client, the supervisor often uses case formulation, which is a technique often used in psychotherapy to facilitate a deeper understanding of client and oneself (Kaufman

& Schwartz, 2004). A case formulation is defined as the concept of organizing, explaining, or making clinical sense out of large amounts of data influencing the treatment decision (Lazare, 1976).

Humanistic-relationship model. The humanistic-relationship model of clinical supervision is grounded in humanistic psychotherapy (Corey, 2015) and integrates existential psychotherapy due to the similarities between these two theories (Watkins, 2012). Humanism emphasizes the pursuit of self-actualization (Farber, 2010). Existential psychotherapy focuses on human beings' freewill to make choices within limitations so as to search for the meaning of a problem (American Psychological Association, 2018; Farber, 2012). Therefore, the humanistic-relationship oriented model in clinical supervision seeks to facilitate supervisee's motivation of self-actualization toward a competent professional during the supervisory process. Farber (2010, 2012) identifies the fundamental competencies that an independent professional therapist should obtain: professionalism, reflective practice, scientific knowledge and methods, relationships, individual and cultural diversity, ethical/legal standards and policy and interdisciplinary systems. Reflective practice is emphasized by Farber and is defined as the ability to self-monitor and self-assess strengths, weaknesses and skill level. Besides developing knowledge of theory and related techniques, the goals of the humanistic-existential clinical supervision model include facilitating a supervisee's growing self-awareness as a therapist and helping the supervisee use such self-awareness as a "change agent" (Farber, 2010). While encouraging the supervisee to use "self" by being present, genuine, empathic and accepting of the clients in the therapeutic relationship, these characteristics are also considered helpful in the supervisory relationship for facilitating an effective relationship with the supervisor (Bernard & Goodyear, 2014; Farber, 2012). Within the supervisory process, the supervisor should respect the uniqueness of the supervisee by tailoring

the most effective approach based on supervisee's level of experience and development (Watkins, 2012).

Cognitive behavioral model. The cognitive behavioral model combines the rationales of both behavioral and cognitive therapy. Behavioral therapy focuses on the learning of normal and abnormal behavior by identifying the observable behavior, the determinants of that behavior and previous learning experiences (American Psychological Association, 2018; Corey, 2015). In contrast, the core principle of cognitive therapy is rooted in an individual's distorted thought process, which is deemed the foundation of their problems. In summary, the cognitive behavioral model is established on the assumptions that "both adaptive and maladaptive behaviors are developed from consequences while irrational thoughts are also addressed" concurrently or sequentially (Bernard & Goodyear, 2014, p. 28).

In the supervisory process, the primary goals are helping the supervisee apply approaches and techniques informed by cognitive-behavioral philosophy to change the client's cognition, emotions and behaviors for recovery (Pretorius, 2006). Corresponding to the structured and goal-directed approaches applied in cognitive behavioral therapy for the client, Liese and Beck (1997) recommend using similar approaches in the supervision model, such as setting an agenda for the supervision session, creating a bridge from the previous supervision session and reviewing homework or eliciting feedback from the supervisee at the end of supervision sessions (Bernard & Goodyear, 2014). The supervisor has the responsibility to provide an appropriate and safe learning environment for supervisee's as well as oversee supervisee's performance in clinical practice by using a more strict approach such as listening to a recording of the session and giving specific feedback (Bernard & Goodyear, 2014; Newman, 2010). The supervisor is also the role model for the supervisee as a clinician exhibiting

professionalism and demonstrating how to collaboratively work with other professionals in order to support the growth of the supervisee's autonomy (Newman, 2010).

Systemic model. The systemic supervision model is established by viewing the supervisee as part of a larger system (Bernard & Goodyear, 2014; Holloway, 1995; Montgomery, Hendricks, & Bradley, 2001). Within this larger system, subsystems such as the academic institution, the university community and the supervisory system all have important influences on the supervisee (Curtis & Yager, 1981; Kaufman & Schwartz, 2004). According to Holloway (1995), the core principle of the systemic supervision model is the “learning alliance between supervisor and supervisee based on the multiple interlinking factors in the relationship of supervision” (p. 6). Multiple interlinking factors refer to the dynamic and the influences of the relationships between client, supervisee, supervisor and facility within the structure of the supervisory relationship (Falender & Shafranske, 2004). With systemic perspective, the supervisor often guides the supervisee to conceptualize the case to identify the problematic interaction. By deliberating on a solution, the supervisee learns to make therapeutic changes during the supervisory process.

The systemic perspective includes: diagnosing the system, not the symptoms; identifying the dysfunction from one area of the system instead of attributing the problem to an individual; and viewing the problem in context. The problem is a result of the interaction within the system; in other words, the presence of symptoms is maintained by the factors and influences from the system. Focusing on the systemic change by making changes to the system or an area of the system can make the existence of symptoms unnecessary. This change refers to a transition to a more stable and balanced form (Celano, Smith, & Kaslow, 2010; Montgomery et al., 2001).

By guiding the supervisee to identify the dynamic of the interaction between clients and their families, the supervisee can further understand family issues, which may be parallel to

previous generations (Celano et al., 2010). Moreover, the therapeutic relationship is considered a common contributor to the therapy outcome as well as a factor in the supervisory system. Therefore, by identifying any dysfunctional interaction between supervisee and client, the supervisor can then help the supervisee develop a positive relationship (Bernard & Goodyear, 2014; Sprenkle & Blow, 2004).

Developmental approach Models. The developmental perspective model of supervision views the growth of supervisee as a continuum process (Kaufman & Schwartz, 2004). A variety of developmental perspective models of clinical supervision are established; however, the integrated development model (IDM) is likely the most popular and comprehensive developmental approach model (Bernard & Goodyear, 2014; Falender & Shafranske, 2004; Stoltenberg, 1997). Instead of considering the purpose of supervision for skill acquisition, developmental perspective supervision provides a stage for the supervisee to “embark on a course of development that will culminate in the emergence of a counselor identity” (Stoltenberg, 1981, p.59). Supervisee’s development can be understood as an on-going process having one pole where the supervisee has limited autonomy, feels insecure and focuses on the implementation of skills, while at the opposite pole the supervisee is equipped with more advanced competencies such as flexibility, tolerance for ambiguity and self-awareness for limitations (Stoltenberg, 1981; Young et al., 2011). Based on a supervisee’s developmental level and individual needs, supervisors have the responsibility to tailor their own behaviors and supervisory approach (Falender & Shafranske, 2004). Stoltenberg (1981) describes the progress of supervisee by using three sequential levels with a final integrated level, each stage has three themes: self-other awareness, motivation and autonomy. Self-other awareness refers to the awareness to self and client. Motivation refers to the commitment to clinical training. Autonomy refers to the level of independence of supervisee and self-other awareness to indicate the change

of the supervisee that could be helpful for supervisor to assess supervisee's current development (Bernard & Goodyear, 2014; Stoltenberg & McNeil, 2010).

Stoltenberg and McNeil (2010) also indicate eight domains as a guideline for the supervisor to evaluate supervisee's performance: (a) intervention skills competence, (b) assessment techniques, (c) interpersonal assessment, (d) client conceptualization, (e) individual differences, (f) theoretical orientation, (g) treatment plan and goals and (h) professional ethics (p.25-27). The supervisory interventions of IDM are adapted from Loganbill, Hardy and Delworth (1982) and Blake and Mouton (1976), who suggest using different interventions based on the developmental level of the supervisee as well as provide supervision interventions for different purposes. Facilitative interventions such as positive reinforcement and active listening are emphasized to provide support for the supervisee. Prescriptive interventions provide guidance and information that is important for the novice therapist who has limited knowledge. Conceptualization interventions guide the supervisee to focus on the client instead of self (Stoltenberg & McNeil, 2010).

Process Approach Models. Process approach models in supervision emphasize the process of supervision rather than using a specific psychotherapy approach informed framework or focusing on the supervisee's developmental process (Bernard & Goodyear, 2014). The purpose of a process approach model is to "provide reliable and valid procedures for studying the supervision process and for assessing outcomes, particularly as related to the congruence between trainee and supervisor tasks and expectations" (Falender & Shafranske, 2004, p. 17). The discrimination model is one supervision process model developed by Bernard (1979); this model provides guidelines for the supervisor to consider when making supervisory decisions (Bernard, 1979). The supervisor may focus on: intervention, which refers to the skill of implementing the intervention; conceptualization, which refers to supervisee's understanding of

the counseling process and clinical decision making; personalization, which refers to how the supervisee maintains the boundary between personal issues and the relationship with client while incorporating personal style within counseling. Lanning (1986) later includes professional issues as the fourth focus, which refers to the ability of handling ethical dilemmas (Lanning, 1986). Furthermore, the supervisor approaches the supervisee based on the supervisee's level of ability and need by choosing one of three different roles: teacher, counselor or consultant. Bernard and Goodyear (2014) map out examples to suggest strategies the supervisor can use when approaching the supervisee through one of the three roles of teacher, counselor or consultant and when focusing on a variety of subsequent purposes . A teacher role may model, give structured feedback or assign homework to address the issue from a specific domain; a counselor role may elicit self-awareness by asking an open-ended question to facilitate supervisee's thoughts and feelings. A consultant role may provide information, assist the session and challenge the supervisee to articulate a different point of view, with the implied trust of the supervisee's independence (Bernard & Goodyear, 2014).

In summary, the models and approaches of supervision in counseling are still emerging in tandem with the continuous growth and refinement of psychotherapy theory. Models of supervision with a combination of theories is not uncommon. Although there are different premises among supervision models, some similarities are observable and each model has its own strengths and limitations. Supervision models are continually evolving and subsequently updating supervisory techniques and formats to address contemporary supervisory challenges such as cultural sensitivity. Professional issues or ethical considerations are often added later, during the development of a model. More recently, multicultural competences are also being significantly weighted in the supervision process (Vera & Speight, 2003). Facilitating the growth of an international student (supervisee) or helping a supervisee gain multicultural competencies

are an additional consideration for the clinical supervisor. With the model and strategies of clinical supervision established by the clinician and the supervisor, the supervisory process can be delivered in a variety of ways. The academic training program and subsequently the supervisor, are responsible for the acquisition and ongoing development of supervisory knowledge, in order to provide the most effective clinical supervision.

Clinical supervision model in music therapy. The growth of clinical supervision in music therapy started by incorporating the models and philosophical perspectives from other healthcare professions like counseling. For instance: Jahn-Langenberg (2001) presented her experience of supervision from the psychodynamic perspective as a framework, which encourages the supervisees to use themselves as a “living instrument” to explore the transference and countertransference relationship with their client. Pedersen (2009) reflected on her application of using the integrated developmental model in clinical supervision that provided her a framework to customize an effective way to facilitate supervisee’s learning based on their developmental stage. Furthermore, clinical supervision in music therapy adopted both individual supervision and group supervision formats from the counseling profession.

While the majority of clinical supervision models focus on an individual supervision format, Frohne-Hageman (2001) introduced an integrative approach from Petzold (1998), which promoted the view of multiple perspectives for group supervision in music therapy, integrating theories from aesthetics, psychology and sociology for consideration when making a supervisory judgment. In particular, Petzold (1998) viewed supervision from the phenomenological perspective (supervisee’s perception of their experience in the environment), the hermeneutic perspective (the interpretation of meaningful event) and an action-oriented perspective (the techniques that can facilitate change). With the lenses of these three different perspectives, Petzold (1998) further categorized the supervisory process into four phrases in a circular cycle:

the phenomenological phase of perceiving and relating, the phase of working through and understanding, the phase of multi-perspective reflection and the phase of integration and training. The supervisor uses techniques and method that can facilitate integration such as free verbal association, imagery and sculpting. Since music is the primary therapeutic medium in music therapy supervision, Frohne-Hageman (2001) and Pedersen (2009) both suggested musical supervisory techniques that can be applied in these four phases such as improvisation, the musical portrait (play instruments to present the client, an event, or client's view) and music listening (Frohne-Hageman, 2001; Pedersen, 2009).

At the same time, the elements of music in music therapy are considered the center of the supervisory process in some other music therapy supervision models. Lee and Khare (2001) promote a music-centered approach for clinical supervision in music therapy to evaluate clinical improvisation in order to “define a supervisee’s clinical maturation as a student and/or developing music therapist” (Lee & Khare, 2001, p. 247). Clinical listening, evaluation, interpretation and judgment are four stages of supervision in a music-centered approach. Clinical listening is the foundation of the music-centered approach which refers to “hearing objectively and precisely the musical constructs contained within the musical relationship” (p.251). With the sensitivities to the music product after clinical listening, supervisees then start to develop skills of reflecting on music content during the clinical evaluation stage. Moving from the clinical evaluation stage to the clinical interpretation stage, the supervisee is encouraged to analyze and interpret the music by exploring the musical interaction and therapeutic relationship. Finally, during clinical judgment, the supervisee uses the understanding of the music to decide the musical goal, non-musical goal and balance between the musical and non-musical goal (Lee & Khare, 2001). Similar to the Lee and Khare (2001)’s music-centered approach, different clinical supervision models within Analytic Music Therapy (AMT), the Bonny Method of Guided

Imagery and Music (GIM) and Nordoff-Robbins Music Therapy consider music at the center of the supervisory process. The trainees are required to complete a certain amount of clinical supervision that is structured within the training component of the curriculum.

Other clinical supervision models are established within the academic setting. Bruscia (2001) developed an apprenticeship model at Temple University to train the graduate student as an apprentice to supervise undergraduate students in the program. The aim of the apprenticeship model is to facilitate supervisor's integration of academic knowledge including supervision theories to a variety of supervisees and guide the transition from preprofessional supervision to professional supervision. There are two layers of supervision within the apprenticeship model, the professor in the academic program provides supervision to the supervisor and the supervisor provide supervision to the undergraduate student as the supervisee. While the supervisor has the responsibility at the clinical training site to observing supervisee's session, the professor in the program oversees the supervisor through the following: individual supervision meetings, apprentice logs that refer to reflective journal writing, ongoing contact and observing the supervisory session. Within the supervisory process, the supervisor is encouraged to view their supervisee from different orientations: action (development of specific behaviors), learning (development of knowledge, insight and skills), client (development of awareness to the client), experience (development of supervisee's self-awareness) and countertransference (development of supervisee's awareness for countertransference). Bruscia also recognized the importance of the individual differences between the role of the professor and the supervisor and the supervisor and supervisee. Potential risks in the supervisory process include the supervisor using interventions at an ineffectual level, presenting expectations too high/too low for the current stage, feeling resistance from the supervisee and allowing personal issue to impact the process.

Formats and Techniques of Clinical Supervision

Format of clinical supervision. Individual, group and triadic supervision are the most common formats for preprofessional clinical supervision; each was approved by the Council for Accreditation of Counseling and Related Educational Programs (2015). Individual supervision is a relatively traditional format of delivering supervision in speech-language pathology and counseling (Anderson, 1988; Campbell, 2011). Group supervision and triadic supervision are often utilized at the same time to fulfill the limitation of individual supervision in clinical training (Borders, Brown, & Purgason, 2015; Falender & Shafranske, 2012). Supervisors choose different arrangements of clinical supervision based on the administrative structure of the program, the number and developmental level of the supervisees. With the combination of models and techniques, clinical supervision is delivered through the format best suited to facilitate growth and development in clinical experience (Campbell, 2011). Each format is described below.

Individual supervision. Individual supervision is defined as the one-on-one meeting between supervisor and supervisee in person or through technology (Campbell, 2011; Dudding & Justice, 2004). In the counseling profession, individual supervision may be called individual case consultation, while in speech-language pathology it is labeled an individual conference. During the supervisory process, the supervisee can use \ knowledge to conceptualize the client and report to the supervisor verbally. Providing process notes and audio or video recording may allow the supervisee to seek for guidance from the supervisor effectively. In addition, the supervisor may also observe the session and provide feedback in real time during the session, using a microphone connected to an earphone worn by the supervisee (Dowling, 2001); feedback can also be provided during a break in the session or after the session. When time and resources

are limited, supervision can also be delivered through video conference (Bernard & Goodyear, 2014).

Group supervision. Group supervision involves a supervisor or supervisors and a consistent group of supervisees meeting occasionally or regularly. The purposes of group supervision include gatekeeping the quality of service and facilitating supervisee's self-awareness through interaction with other members of the group (Bernard & Goodyear, 2014). In the group format, the supervisor not only has the responsibility of focusing on the supervisory relationship with individual supervisees, but also has the obligation to address group dynamics, processes, cohesion and management (Campbell, 2011).

Group supervision provides supervisees with the experience of receiving group validation, peer support, companionship and experience sharing which is missing from the individual supervision format (Falender & Shafranske, 2012). However, while group supervision may take less time and effort, it can be challenging to address an individual's needs within a group structure (Anderson, 1988). Bernard and Goodyear (2014) also discuss the concern of confidentiality and supervisee's learning impacted by a negative relationship with a group member. Furthermore, since group supervision has its strengths due the similarities with group therapy in counseling, a supervisee benefits from learning the group process for their own leadership in group counseling. However, the supervisee is not able to duplicate the group process into individual counseling sessions (Bernard & Goodyear, 2014).

In the counseling profession, group supervision is more common during clinical training. Most practicum or internship trainees experience both individual and group supervision. Case presentation and work-related issues are usually the focus of the group supervision in counseling. In speech-language pathology, group clinical supervision occurs less frequently than the individual format in the United States. However, the speech-language pathology field in

Australia places more attention on group supervision through peer learning (Second- and final year practicum student pair up to attend group supervision) or case staffing (Senior practicum report case history, assessment, intervention example as demonstration) (Dowling, 2001).

Triadic supervision. Triadic supervision refers to clinical supervision that involves a supervisor and two supervisees (Borders, 2012). The Council for Accreditation of Counseling and Related Educational Programs (2001) defines triadic supervision as “a tutorial and mentoring relationship between a supervisor and two supervisees” (p. 105). In triadic supervision, the supervisees may have the same or different levels of clinical experience. During the supervisory process, the supervisees rotate to be the role of supervisor for giving feedback or to engage in a discussion regarding cases that supervisees work with together or separately.

Techniques of clinical supervision.

Techniques were defined as “a method of accomplishing a desired aim” (Technique, 2018). Therefore, the supervisor used techniques in order to achieve specific goals in the supervisory process. The supervisory techniques were often adopted from counseling field. Researcher discussed the following techniques which was commonly utilized in the clinical supervision:

Interpersonal process recall (IPR). Feedback is given while the supervisor and supervisee watch the videotape of the music therapy session together. The aim of IPR is to “facilitate trainee’s understating of themselves and client dynamics, especially the role of non-verbal behavior,” which influence clinical decision making (Campbell, 2011, p. 44; Falender & Shafranske, 2012). The supervisor may pause the video to give positive or constructive feedback and ask thought provoking questions when the supervisor observes “something important is happening”. Supervisees are also encouraged to pause the video to seek guidance during the process as well. Additionally, supervisors can adopt IPR in both individual supervision and

group supervision as a facilitator to elicit the awareness to self and client (Bernard & Goodyear, 2014).

Verbal/ Written feedback. Feedback is any information given in response to an event, action or process related to a goal or standard in the therapy session from one individual to another individual. Feedback includes verbal and written forms. A supervisor could provide written feedback in narrative, checklist or rating scale formats (Anderson, 1988; Dowling, 2001). The content of the feedback should be balanced between positive and constructive (Burkard, Knox, Clarke, Phelps & Inman, 2014; Merriam-Webster, 2018). The process of giving feedback could be from the supervisor to the supervisee, or feedback could also be reciprocated.

Self-critique. A supervisor directs supervisees to reflect on their performance during the music therapy session regarding their facilitation, musical skills or therapist effectiveness. Self-critiques could be applied during the process of watching a videotape of the session or after the facilitation of the session without availability of a videotape. Self-critiques are considered an effective technique to facilitate the supervisee's growth as a self-aware, competent therapist. Supervisees may have difficulties observing themselves objectively, so it is suggested to incorporate video/audio recording watching with self-critique during the supervisory process. While supervisees are supervising themselves, discussion regarding their behavior with a supervisor is beneficial. Crago (1987) suggests encouraging the clinician to self-evaluate a session by identifying what was successful, what was not successful and what was surprising (Crago, 1987; Dowling, 2001).

Facilitating reflection. Reflective thinking is essential for contextually understanding one's self as a therapist working with a client. The ability to conceptualize the client and the client's needs is foundational to making clinical decisions. Socratic questioning, journal writing and reflective team are four methods presented by Griffith and Frieden (2000) to facilitate

supervisee's reflections on the therapeutic process. During Socratic questioning, a supervisor uses "what" and "how" questions to promote the thinking process in order to facilitate learning. Socratic questioning can be applied in both group and individual supervision formats. During journal writing, a supervisor encourages supervisee to become involved in a reflective thinking process. The content of the journal could be non-structured (free writing) or with prompting questions. During IPR, a supervisor promotes reflective thinking by asking thought-provoking questions while the supervisee watches the session video. A reflective team is primarily applied in family and marriage therapy. During a reflective team process, a supervisor facilitates a group of clinicians to examine a family system together (Bernard & Goodyear, 2014; Griffith & Frieden, 2000).

Modeling. The supervisor demonstrates facilitation skills, musical skills or therapist effectiveness skills for the supervisee. The supervisor may model these skills during or after the session for the purpose of providing an appropriate model for the supervisee to imitate.

Role play. Supervisor directs supervisees to demonstrate their facilitation, musical skills, or therapist effectiveness in a mock context as the therapist during the supervisory process. The supervisee may also role-play as a client, member of the family or supervisor depending upon the purpose of the supervisory process. "The essence of role-playing is to switch from talking about problems with clients to experiencing them in the here and now; for example, as a supervisee is talking about a particular client situation and what they plan to do, the supervisor might say, demonstrate to me how you plan to confront to this client. What will you say and how will you say it" (Campbell, 2006, p.105).

Self-disclosure. Supervisors' disclosure of their own past experiences or their own self-reflection may be part of the supervisory relationship with the supervisee. Self-disclosure could be used to reduce a supervisee's anxiety when the supervisor empathetically applies it. Self-

disclosure may also help the dyad work through challenging supervisory relationships (Campbell, 2011).

Peer feedback. In a group or dyad supervisory format, the supervisor invites the supervisee's peer to provide positive or constructive feedback to the supervisee regarding musical skill, facilitation, therapist effectiveness or the reflection of client's behavior. Feedback given between peers was also an opportunity to view the clinical experience as a supervisor.

Clinical Supervision in Music Therapy

Clinical supervision in music therapy is significant for the following purposes: facilitating the development of supervisee, assisting the transition from theory to practice and fostering the autonomy as a therapist. Music therapy supervision can be divided into three categories: preprofessional supervision for those who have not yet fulfilled requirements for the credential in music therapy including practicum or internship, professional supervision for those who have already received their board certification credential through institute trainings such as Neurologic Music Therapy or those involved in graduate level practicum for individuals engaged in advanced training in music therapy. The clinical supervision addressed below is primarily focusing on preprofessional supervision for the purpose of this research. In the current research, preprofessional supervision specifically refers to the supervision for clinical training as practicum or field study in an academic institution before entering the internship. The supervisees are primarily students who are pursuing a degree in music therapy and fulfilling the requirement prior to taking the board certification exam.

Compared to the other allied health fields mentioned earlier, the development of the music therapy profession is considered most recent. Therefore, music therapy supervision is influenced by related health care professions who have longer clinical supervision histories, such as nursing, speech-language pathology and counseling. Moreover, the frameworks are often

adopted or derived from clinical supervision in the counseling field. While similarities between music therapy and other professions are observable, music therapy needs to concentrate on the growth of musical skills and allied knowledge from other health fields such as psychology, sociology, anatomy and physiology (Brookins, 1984). With such complex processes of clinical supervision (Jackson, 2008), the British Association of Music Therapy (BAMT) (2012) provides general guidance: “Clinical Supervision is defined as a formal, collaborative process in which two or more professionals meet to discuss the clinical content and process of the supervisee’s work” (p.5). More specifically, BAMT indicates that the discussion during the professional supervisory process may include the analysis of verbal, musical, behavioral, emotional and psychological domains. Through the process of supervision, the supervisor and supervisee establish a relationship to focus on addressing “the complexities involved in helping supervisee in their on-going development as competent and compassionate professionals” (Forinash, 2001, p. 1). Forinash (2001) further describes the supervisor and the supervisee by indicating that “both are complex individuals who bring their unique perspectives and multiple levels of experiences to the relationship and to the understanding of music therapy” (Forinash, 2001, p. 1). Besides the function of assisting the growth of the supervisee during their education, both BAMT (2012) and Forinash (2001) mention the role of supervision is also for ensuring the welfare of the client. Although the guideline of clinical supervision defined by BAMT target supervision between two professionals, safeguarding the quality of music therapy services is especially important for preprofessional supervision while the supervisee is still establishing skills and competencies.

The American Music Therapy Association (2013) establishes the professional competencies as a standard for music therapy education and clinical training, which are presented under three major categories; music foundations, clinical foundations and music therapy. Music foundations includes music history and theory, composition and arranging skills,

major performance, functional music skills, conducting skills and movement skills. Clinical foundations include therapeutic application, therapeutic principles and the therapeutic relationship. Music therapy includes foundations and principles, client assessment, treatment planning, therapy implementation, therapy evaluation, documentation, termination/discharge planning, professional role/ethics, interprofessional collaboration, supervision and administration and research methods (American Music Therapy Association, 2013). While clinical supervision is required for clinical practicum in music therapy education, the professional competencies provides a foundation for preparing supervisees to be ready for internship and to enter the profession.

Brookins (1984) invited internship directors to evaluate the necessities from four areas of competence: performance skills, academic knowledge, personal qualities and interpersonal skills for students based on their experience of supervising students in the past. Internship directors noted psychology, music therapy principles and theory and music therapy techniques as the most important academic knowledge for internship. Students are also expected to be equipped with competencies in piano, guitar and voice. Additionally, the used of percussion instruments has caught more attention for academic and clinical training. Professional music therapists indicated that music therapy trainees should receive more training in established percussion instrument skills related to clinical practice (Scheffel & Matney, 2014). Important personal qualities of a supervisee include emotional maturity, students' independence and the desire for learning. Interpersonal skills such as expressing needs and feelings, assertiveness and sensitivity are essential due to students working with supervisors, clients and other colleagues (Brookins, 1984).

The definition of practicum. Music therapy training contains two parts: academic and clinical training (Brookins, 1984). As indicated in the *Standards for Education and Clinical*

Training by AMTA, clinical training is an essential component for students pursuing degrees in music therapy. Clinical training can be further categorized into practicum and internship. The focus area of this study is to investigate the music therapy supervision for clinic practicum while students are acquiring competencies for internship. “The primary purpose of practicum is to expose the student to various type of clients and treatment philosophies and to allow the student to explore music therapy as a career choice” (Decuir & Jacobs, 1990). More specifically, practicum clinical training provides the supervisee with opportunities for incorporating academic theory and clinical experience (Forinash, 2001). The academic institution providing music therapy training has the responsibility to offer practicum experience with at least three different populations in diverse settings under the direct supervision of a credentialed music therapist. Practicum supervisors are also required to observe at least 40% of music therapy sessions (American Music Therapy Association, 2018a).

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) has become an accepted methodology within interpretive approaches to research, not only in psychology but in fields studying social issues and health sciences (Brocki & Wearden, 2006; Chapman & Smith, 2002; Smith et al., 2009). More specifically, researchers used IPA to explore the lived experiences of individuals in nursing, speech-language pathology and counseling. IPA research in nursing was conducted to understand the perception of patients with specific diagnoses who received treatment in order to improve the quality of care (Cooper, Ells, Ryan, & Martin, 2018; Mjøsund et al., 2017). In speech-language pathology, Brown, Worrall, Davidson and Howe (2015) explored therapists’ perspectives on clients living successfully with aphasia; the authors identified some factors for positive outcomes after they analyzed the verbal accounts from semi-structured interviews. The identified factors can be incorporated into treatment in the future (Brown et al., 2015).

McCandless and Eatough (2012) conducted a study using the IPA methodology to investigate the experience of supervisors promoting reflexive learning of supervisees in order to facilitate the development of the family therapist. Singh-Pillay (2016) explored the non-disclosure between clinical supervisor and their supervisee. Macandless and Eatough (2012) and Singh-Pillay (2016) both used semi-structured interviews to collect data, which allowed researchers to analyze the supervisory relationship through participants' verbal accounts (McCandless & Eatough, 2012; Singh-Pillay, 2016).

Recently, the use of IPA in music therapy field has explored the lived experience and sense making process of researchers interested in particular populations. According to Smith and Osborn (2015b) fewer participants are recommended to acquire rich data from individuals, so research using IPA typically has a small number of participants from as few as three (Venkatarangam, 2017) to nine participants (Solli & Rolvsjord, 2015). Researchers have not only studied the experience of music therapy clients (Erasmus & Merwe, 2017) but also examined the experience of families (Fairchild, Thompson, & McFerran, 2016), caregivers (Baker & Yeates, 2017; Wells, 2017) and staff members (Baker & Stretton-Smith, 2017). Professional music therapists were also recruited to participate in an IPA study as clinician s(Christodoulou, 2014), educator (Lloyd et al., 2017) or supervisor (Lieberman, 2017).

As suggested by Smith and Osborn (2015b), most researchers invite participants to attend a semi-structured interview due to its non-directive and flexible nature. Before the semi-structured interview, researchers organized an interview guide with a warm-up opening followed by open-ended questions. In order to facilitate meaningful and in-depth conversation during the interview, the researcher usually prepared a list of probes or prompts along with the interview guide to stimulate conversation and provide opportunities for sharing and sense making (Baker & Yeates, 2017; Christodoulou, 2014; Fairchild et al., 2016) as needed. Both Kowlessar and

Corbett (2009) and McCaffrey (2013) used probes suggested by Babbi (1992) such as “Can you elaborate more?”, “How is that” or “Anything else?” to elicit responses from the participants (Kowlessar & Corbett, 2009; McCaffrey, 2013). While some of the IPA research in music therapy focused on the personal sense-making process from a participant in the target environment, other research places more attention on the interaction or the relationship between two interested individuals. Therefore, a pair of participants such as a therapist and the client are sometimes recruited to participate in the interview together (Lee, 2014).

Besides the semi-structured interview, structured interviews (McLean, 2016) and focus groups (Sims, 2017) were also used to collect data in IPA studies. During the process of data collection, the researcher occasionally incorporated video watching or Interpersonal Process Recall (IPR) into the interview schedule. Lee (2014) conducted an IPA research study to explore the non-verbal interaction between therapists and their clients with intellectual disabilities, the researcher invited the therapist to watch the video of a music therapy session at the end to the interview to identify the meaningful moment; Lee and McFerran (2015) further combined IPA with video watching of music therapy sessions to develop the “Interpretative Phenomenology Video Analysis” (IPVA) methodology, providing specific steps.

After gathering the data, researchers who conducted IPA research in music therapy followed the six-steps of data analysis suggested by Smith et al. (2009) (Baker & Stretton-Smith, 2017; Baker & Yeates, 2017; Christodoulou, 2014; Lieberman, 2017; McLean, 2016; Sadowski, 2017; Solli & Rolvsjord, 2015; Venkatarangam, 2017): (a) immersion in original data, (b) initial noting, (c) developing emerging themes, (d) searching for connection across emergent themes, (e) moving to next case and (f) looking for patterns across cases (Smith et al., 2009).

Furthermore, Lieberman (2017) conducted an IPA study to understand the development of trust and safety between clinical supervisor and music therapy intern. Safety and trust are

identified has having a positive influence in the supervisory relationship, which is essential for clinical training in music therapy. However, there is minimal research investigating the establishment of safety and trust of clinical supervision in music therapy. IPA was determined to be an appropriate methodology to explore the lived experience of these participants.

Accordingly, the aim of the research was to investigate "How do safety and trust within supervisory relationship impact the participant's work as intern or professional as well as their personal development?" and "How do music therapy interns experience safety and trust, or lack or safety and trust between themselves and their clinical supervisor? " Lieberman used a semi-structured interview, followed by the steps of data analysis promoted by Smith et al. (2009). She discovered five themes that facilitate the establishment of safety and trust in supervisory relationships: supportive context, invested supervisor, straightforward role dynamic, sufficient clarity and intern identity. The subthemes of each theme were also identified in the results section by using quotes from participant's verbal account to interpret the how do safety and trust impact the supervisory relationship. Results provided insight for clinical supervisors who wish to establish safety and trust with their supervisee, as well as for researchers to explore more about clinical supervision in music therapy in the future.

Problem Statement and Research Questions

Clinical training is an essential component for students pursuing degrees in music therapy to be qualified to take the music therapy board certification exam (American Music Therapy Association, 2018a; CBMT, 2011). As indicated in the Standards for Education and Clinical Training by American Music Therapy Association (2018a), supervised clinical experience with a variety of populations is required before entering internship. Various clinical supervisors work in partnership with academic faculty to develop students' professional competencies. During pre-internship training (practicum), a qualified and credentialed supervisor provides direct

supervision to students, observing the student for a required minimum of 40% of clinical sessions. Direct supervision includes observation of the student's clinical work with feedback provided to the student music therapist (American Music Therapy Association, 2018a). A supervisor serves the role of facilitating the development of the student music therapist as well as protecting the welfare of the client. With the supervisor and supervisee cooperating during this learning process, the dialogue between these individuals takes on an important role of establishing professionalism and the diverse behaviors leading to therapeutic effectiveness.

Music therapy serves a wide spectrum of populations; it requires a music therapist to have knowledge of different clientele, therapeutic facilitation and music skills. By creating musical involvement within the therapeutic relationship, music therapists address outcomes within psychological, physical, cognitive and social perspectives (American Music Therapy Association, 2018b). The music element in music therapy is unique when compared to other professions such as nursing, speech-language pathology and counseling and as such creates an additional complexity.

The outcome of supervision has a direct impact on a supervisee's therapeutic effectiveness and the subsequent growth of clients within the complexity of music therapy (Jackson, 2008; Kennelly, Daveson, & Baker, 2016). Music therapists use themselves as an 'instrument' to work with others in a therapeutic relationship. Within a therapeutic relationship, the music therapist needs to recognize the impact of one's own feelings, attitudes and actions on the client and the therapy process by establishing and maintaining an interpersonal relationship with clients that are appropriate and conducive to therapy (American Music Therapy Association, 2018a). While supervision is aimed as facilitating the learning process of skills inherent in the particular discipline, it also often brings personal issues to the surface (Kim, 2008). In other words, supervision is a process fostering supervisee's self-awareness to identify

their own strengths and limitations in the therapeutic relationship. To deliver effective supervision, studies in music therapy explored the supervisee's supervision experience in clinical practicum regarding the supervisory format, challenge, techniques and relationship (Abbott, 2015; Baker & Krout, 2011; Lieberman, 2017; Wheeler, 2002; Wheeler & Williams, 2012). Supervision is a collaborative process between the supervisor and supervisee; however, the research of clinical supervision in music therapy weighs more on investigating the supervisory process from the supervisee perspective. Literature from the perspective of clinical supervisor exploring the supervision in music therapy is limited.

As an international student receiving music therapy training in the United States, the researcher had the unique experience of being supervised by both domestic and international music therapists. Currently, the researcher is a graduate teaching assistant in a clinical training program that provides her the opportunity of supervising future music therapists. Experiencing these different perspectives of music therapy training brought about the motivation to observe and ascertain the models and strategies of music therapy clinical supervision from the perspective of a select group of domestic and international supervisors.

Therefore, the aim of this IPA study was to explore the process of clinical supervision for music therapy practicum from the perspective of the supervisor. As a growing field within helping professions, music therapy academic and clinical training is intentional in preparing future therapists to be therapeutically impactful post clinical training. With a diversity of models, formats and strategies used for clinical supervision delivered by the supervisor, the exploration of clinical supervisors' lived experience in music therapy practicum were discovered by conducting semi-structured interviews. To answer that primary research question, what is the process of clinical supervision for music therapy practicum from the perspective of the clinical supervisor? the following questions were used to design the semi-structured interview guide:

1. How do participants describe their supervision experience as a supervisee and a supervisor?
2. How do participants view their supervision model?
3. How do participants interpret their supervisory process and the supervisory relationship?
4. How do participants interpret the supervisory challenge they experienced if any?
5. What supervision formats and techniques do they engage in?
6. How do participants make sense of the factors that impact their model, process, formats and techniques?
7. How do participants describe their experience of supervising domestic and international students?

Chapter 3: Method

Theoretical Framework and Research Methodology

Phenomenology is an approach in philosophy to study phenomena such as human lived experience or consciousness (Forinash & Grocke, 2005; Smith, 2018; Smith et al., 2009). Forinash and Grocke (2005) point out the foci of phenomenological inquiry: complexity, intentionality, bracketing and the essential structure. Complexity implies the complexity of human being. Intentionality refers to the idea that human consciousness is lead toward certain objects (such as music) or concepts (such as emotions) while experiencing an event. Bracketing implies that the researcher is able to be aware of the influence from the researcher's beliefs and take the researcher's perspective as a unique input when interpreting participants' lived experience. Essential structure refers to the necessary element in the experience which can help the researcher to differentiate the phenomenon and other phenomenon.

The research methodology for this study was an Interpretative Phenomenological Analysis (IPA). IPA has idiographic, inductive and interrogative characteristics through exploring individuals' experiences and sense making processes in personal or social contexts (Chapman & Smith, 2002; Smith, 2004). IPA's idiographic characteristic indicates the commitment to the specific such as limiting the number of participants which is in contrast to making general conclusions at the population level (Smith et al., 2009). Inductive refers to the freedom of allowing "unanticipated topics or themes to emerge during analysis" (Smith, 2004, p. 43) by techniques such as semi-structured interviews. Interrogative is indicated as an aim of IPA to use interrogation or questioning to make a contribution to the professional field (Smith, 2004). Instead of establishing an objective narrative, IPA focuses more on the subjective report of the participants (Brocki & Wearden, 2006). A subjective report provides a path for the researcher into the participants' world of understanding and perceived experiences. Through the reflection

of the participants, the researcher incorporates an interpretation of the phenomenon and a depiction of individuals' mental and emotional states in an effort to produce an analytic report (Brocki & Wearden, 2006; Smith & Osborn, 2015b).

For the aim of acquiring “rich” and in-depth reflections, fewer participants are suggested when conducting an IPA study due to the necessary detailed analysis and examination of the verbal account as research data (Hefferon & Gil-Rodriguez, 2011; Larkin, Watts, & Clifton, 2006; Smith & Osborn, 2015b). The exploration involved in an IPA study is focused on the participants' experiences and sense making processes within a target environment that is significant to the area of interest of the researcher. Therefore, purposeful and homogenous sampling is typically advocated within an IPA study.

Interviews, focus groups or diaries are common methods of data collection in an IPA study gathered purposefully from sampled participants (Larkin et al., 2006; Smith & Osborn, 2015b). Among a variety of data collection methods, the semi-structured interview allows the researcher the flexibility to obtain not only responses to the interview questions planned by the researcher but also to garner unexpected data collected during the interview process. Giving researchers the freedom to explore interesting areas arising during the interviews beyond the scope of the interview guide allows participants to express reflection and interpretation in their own voices (Larkin et al., 2006).

IPA studies are able to provide an in-depth account from participants in a targeted area which may establish the foundation for advancing the development of a certain field or profession. For the primary purpose of exploring clinical supervisors' experiences while supervising student music therapists in a large music therapy program, the methodology of IPA was chosen to determine the point of view of these participants. The selected data collection method includes semi-structured interviews with the purpose of giving a voice to intentionally

selected participants while understanding their experiences in the area of focus, clinical supervision.

Human Subjects Approval, Participant Recruitment and Consent

In order to protect the rights and privacy of individuals who volunteered to participate in a research project, consent documents and recruitment materials must be submitted to and reviewed by an Institutional Review Board (IRB) before conducting the research study. The researcher completed the Human Research Protection Program by providing information about participants, recruitment protocol, consent process and any additional information related to the study required by the IRB and submitted through an e-compliance system at the researcher's affiliated university. The researcher submitted the following as supplemental material: (a) an information statement, that will serve as the consent process documentation; (b) a recruitment email script; (c) the preliminary questionnaire; and (d) the semi-structured interview guide was submitted as supplemental material.

Participants

Smith and Osborn (2015b) propose six participants for a student who will be conducting research for a thesis required for a master's degree. Therefore, six participants were recruited from a large Midwest university of the United States. Four doctoral students and two master's students currently or recently supervising undergraduate and graduate equivalency students as part of the clinical training program were purposefully sampled to participate in individual interviews with the researcher. All six clinical supervisors were board-certified music therapists, two originally non-domestic students who received their music therapy training in the United States, while four were American citizens. Participants' clinical and supervising experiences within the academic program were gathered as part of the demographic portion before the

interview process through a preliminary questionnaire. The participants were instructed to bring the completed preliminary questionnaire to the interview.

Target Environment

The target environment was the clinical training portion of the music therapy program at a large Midwest university with a four-year curriculum for undergraduate students and a two-year curriculum for graduate equivalency students. Students started clinical training under the supervision of a clinical supervisor after they completed fundamental courses. Clinical supervisors served on a clinical supervision team with support from faculty members via a weekly clinical meeting and ongoing electronic and personal communication as needed. Through the clinical supervision team meeting, supervisors obtained guidance and support from faculty and other clinical supervisors regarding student and client issues. Each clinical supervisor was assigned approximately seven to nine student music therapists each semester. Supervisees were placed in either individual or group settings and may be leading sessions independently or as part of a dyad team based on level of competence and semester in the clinical practicum sequence. The responsibilities of clinical supervisors included guiding the treatment process development, observing music therapy sessions, providing facilitation feedback in verbal and/or written formats and grading documentation and related assignments.

Semi-structured Interview Guide

Semi-structured interview is considered the best and most effective method to collect the perception of experiences and determine the sense making process from participants in IPA research (Smith & Osborn, 2015). A semi-structured interview process facilitated dialogue between the researcher and the participants during the interview due to its flexibility. This flexible format allows the researcher to modify questions based on participants' responses and to investigate any interesting areas that may arise during the interview (Smith & Osborn, 2015)

Therefore, this study used a semi-structured interview for data collection with the participants. First, the interview guide (Appendix D) started with an introduction to provide information as well as build rapport with the participants (Smith & Osborn, 2015). Second, in order to understand how participants' own experiences affects them as supervisors, the researcher inquired as to the participants' clinical and supervising experience prior to and within the academic program. Finally, the researcher started a dialogue to investigate their experience of supervising students in the music therapy program by having a set of questions outlined with specific prompting questions based on participants' responses. The interview guide served to support the dialogue instead of setting a strict order for interview questions (Smith & Osborn, 2015). By beginning the conversation with short and general questions, the participants had the freedom to decide how much to share about the topic (Hefferon & Gil-Rodriguez, 2011). The content of the interview questions was impacted by information obtained in the literature review and was formatted from a relatively broad concept to more specific ideas. For instance, the researcher had the participants describe their model (broad) of clinical supervision and then explained embedded supervisory techniques (specific) used in order to facilitate the development of their supervisee.

Procedures

After receiving permission to conduct the interviews from the IRB, the researcher sent out an invitation for participation in the interview via email. General topic of the research, specific purpose of the research and information regarding the interview process were included in the recruitment email (Appendix A) which contained an information statement for informed consent (Appendix B). If the participant was willing and consented to being interviewed, the researcher scheduled a 45-60-minute interview to be held at a quiet and private location to avoid possible distraction during the interview as well as maintain confidentiality for the content

disseminated by the interviewee. Although the expected length of the interview was from 45 to 60 minutes, three of the interviews were completed between 40 and 45 minutes. The researcher also conducted some interviews through online video communication software to accommodate the availability of the participants. For interviews conducted in person, the researcher used a Sony-recorder ICD-UX523F; yet, for the interviews conducted via Facetime or Skype, the researcher used the computer's Quick Time application. The researcher sent out the preliminary questionnaire for the participant to complete and bring to the interview. The researcher started by greeting participants before they read the information statement and delivered their completed preliminary questionnaire either in hardcopy or in digital format to the researcher. One of the participants forgot to complete the preliminary questionnaire prior to the interview so the participant filled out the form when the participant first met with the researcher. Each participant was assigned an alphabet as pseudonym to maintain confidentiality.

The researcher started to record the interview and proceeded with the interview process by asking predetermined questions from the semi-structured interview guide. During the interview, the researcher followed the semi-structured interview guide but adjusted the process slightly (as noted below), since flexibility was needed based on participants' reactions to each question:

1. The researcher asked a question earlier than initially intended if the participants said something related to a proposed later question.
2. The researcher withdrew a question if the participants provided an answer earlier.
3. The researcher asked questions outside of the predetermined semi-structured interview guide if a significant topic arose.
4. The researcher re-phrased a question if the participant did not seem to understand.

The researcher printed the interview guide and took notes on the guide in order to document non-verbal behaviors along with verbal reflections from participants. Non-verbal behaviors such as body language, tone of voice and emotional reactions were noted by the researcher in conjunction with verbal content. By the end of the interview, the researcher informed the participant she would send them quotes and interpretations after the data analysis was completed for the participants to confirm the interpretations and share their concerns. After completion of the interview, the researcher transferred the recordings of the interviews on to an external drive with password protection. The researcher listened to the interview recordings and hired an individual to assist with transcription of the verbal content. The left-hand margin of the electronic document was left blank for the purpose of note taking during data analysis.

Data Analysis

The researcher analyzed the data after all interviews were transcribed from audio recordings with the assistance from a hired transcriber. The hired transcriber completed the required training in human subject protection through the Collaborative Institutional Training Initiative (CITI) program at the researcher's university affiliation, as requested by the Human Research Protection Program. The hired transcriber completed two of the six transcriptions and after he completed these transcriptions, the researcher verified accuracy. The identifiers of the participants were eliminated from the transcriptions with each participant labeled by an alphabet letter to maintain confidentiality. The steps for data analysis that were applied were adapted from Smith et al. (2009) and Smith and Osborn (2015a) with slight modifications by the researcher as needed and indicated in italics after each step:

1. Researcher printed out hard copies of transcripts and read them several times until familiar with the content of the transcripts. (*no alteration*)

2. Researcher wrote notes in the space on the left-hand side of the transcript and highlighted the phrases or words that were important or significant in the transcripts. While writing the notes for the transcripts, descriptive (analyze the verbal account to describe content such as a key word, phrases or explanation), linguistic (focus on how do participants use the language such as the tone of voice, pronunciation, pauses, laughter, functional aspects of language, repetition, degree of fluency) or conceptual comments (interpret or reflect on the verbal account) were utilized (Smith & Osborn, 2015b, pp. 84-88). *(The researcher also wrote down the explanation of vocabulary words from an online dictionary as needed.)*
3. Researcher analyzed relationships and patterns from the notes written as part of the previous step. By making the connection between patterns from the previous notes, the researcher clustered similar relationships and patterns across emergent themes. *(When the researcher identified possible connections within the same interview, lines and arrows were drawn to connect information. The researcher typed out the notes written during the first interview into a Word document. After reading and examining notes from the first interview, the researcher categorized the notes using different colors. Each color represented a different theme. Notes with the same color were dragged together in the document for clustering similar relationships and patterns across emergent themes.)*
4. Researchers made connections between the emergent themes to establish superordinate themes. *(no alteration)*
5. Researcher repeated steps 1 to 3 until all transcripts were analyzed. *(no alteration)*
6. Researcher looked for commonalities and differences of emergent themes across the cases. *(The researcher placed the coded data from all the interviews which have the same color together in a new file for classification. By putting comments next to the data, the*

researcher made connections between the emergent themes to establish super-ordinate themes.)

7. Researcher wrote narratives based on themes gathered from transcripts and interpretation compiled by the researcher with assistance of supporting quotes from the transcripts of the verbal accounts and interview notes reflecting non-verbal behaviors. Commonalities and differences between themes and observations across all cases were discussed in the narrative as well. *(no alteration)*
8. Researcher gathered feedback by asking participants to complete member checks by having participants review and approve any quotes used in the study. *(no alteration)*

Research Biases: Bracketing and Researcher Lens

In phenomenological inquiry, bracketing the research bias while exploring the human experience is essential (Smith et al., 2009). Bracketing is often discussed in IPA while phenomenology is the theoretical framework of IPA. Husserl (1989) recommends the process of phenomenological reduction in the phenomenological study which implies that the researcher put away the natural attitude to the phenomena so that the phenomenon can be reported objectively (Bradbury-Jones, Sambrook, & Irvine, 2009; Dowling, 2007). Creswell (2006) further indicated that researchers should discuss personal experiences or reflection for bracketing themselves out of the study. However, bracketing does not remove the researcher out of the study completely, rather helping the researcher to identify and step away from the preconception and assumption of the interested phenomena (Bradbury-Jones et al., 2009; Creswell, 2006).

As the researcher of the current study, I am a board-certified music therapist studying for a master's degree in music therapy at a large university in the Midwest. I have a bachelor's degree in music therapy and have completed the six-month internship before being admitted into the master's program. I served as a clinical supervisor of music therapy practicum in the

program. The inspiration for exploring the clinical supervision process in music therapy was based on my process of learning how to become a supervisor. I had experience supervising practicum students with different levels of development, a variety of needs and different culture backgrounds. In order to provide effective clinical supervision to facilitate the growth of musical skills, facilitation skills and therapist effectiveness, I had to make supervisory decisions based on the knowledge of different supervision models, formats and strategies. Therefore, I was curious about the experience of other clinical supervisors in the same music therapy program. The participants of the semi-structured interviews were my colleagues on the same clinical team who attended the same graduate study program with me. Therefore, I may know some information about the participant's background or supervising experiences prior to implementation of this study.

Chapter 4: Results

Aim of the Interpretative Phenomenological Analysis (IPA)

The aim of this IPA was to explore the process of clinical supervision for music therapy practicum from the perspective of clinical supervisors. As a growing field within helping professions, music therapy clinical training has a significant impact on students becoming therapeutically impactful therapists in the future. Therefore, clinical supervisors' lived experiences supervising music therapy clinical practicum were investigated by conducting semi-structured interviews to answer research questions. The researcher created an interview guide by categorizing interview questions within specific topics. The examined topics were: (a) experience as supervisee; (b) experience as supervisor; (c) model; (d) process; (e) method, techniques and strategies; (f) format; (g) assignment, behavior and challenges; and (h) culture awareness and sensitivity in clinical supervision. Data gathered from each clinical supervision topic provided the answers for the following research questions (accompanying questions from the initial interview guide are provided for reference with different topics and responses occasionally informing more than one research question):

1. How do participants describe their supervision experience as a supervisee and a supervisor?
 - a. Clinical supervision experience as a supervisee.
 - i. What was your supervision experience during your clinical practicum training?
 - ii. How would you describe the individual who was your best supervisor?
 - iii. Please describe your most challenging impactful moment as a supervisee within supervision during your clinical training

- b. Clinical supervision experience as a supervisor.
 - i. Please describe your experience as a supervisor.
 - ii. Please describe your most positive impactful moment as a supervisor.
 - iii. Please describe your most challenging impactful moment as a supervisor. What did you do to address the challenge?
- 2. How do participants view their supervision model?
 - a. Clinical supervision model.
 - i. How would you describe your approach to supervision?
 - ii. Do you approach from a particular model or orientation?
- 3. How do participants interpret their supervisory process and the supervisory relationship?
 - a. Clinical supervision process.
 - i. How do you describe the supervisory process?
 - ii. How do you describe the relationship between supervisor and supervisee?
 - iii. How do you describe your strengths as a supervisor?
 - b. Clinical supervision format, assignment, behavior and challenges.
 - i. What do you usually focus on during the supervisory process?
How do you describe the focus of supervisory process?
- 4. How do participants interpret the supervisory challenge they experienced if any?
 - a. Clinical supervision experience as a supervisor.
 - i. Please describe your most challenging impactful moment as a supervisor. What did you do to address the challenge?
 - b. Clinical supervisory process.

- i. How do you describe your challenges as a supervisor?
- 5. What supervision formats and techniques do they engage in?
 - a. Clinical supervision method, techniques and strategies.
 - i. What kind of techniques and strategies do you use?
 - b. Clinical supervision format, behaviors and challenges.
 - i. If you use more than one supervision format, is your supervisory process different in these formats? If so, how?
- 6. How do participants make sense of the factors that impact their model, process, formats and techniques?
 - a. Clinical supervision method, techniques and strategies.
 - i. How do you decide what to use and when?
 - b. Clinical supervision format, assignment, behavior and challenges
 - i. How do you decide what format to use?
 - ii. What do you usually focus on during the supervisory process?
How do you describe the focus of supervisory process?
 - iii. What have you experienced as the differences between supervising first-semester and last-semester practicum students?
 - iv. What have you experienced in terms of challenges for supervisees?
- 7. How do participants describe their experience of supervising domestic and international students?
 - a. Cultural awareness and sensitivity in clinical supervision.

- i. Do you use a different approach when supervising domestic supervisees and international supervisees? Why? And what are the differences?
- ii. Was your supervisor culturally sensitive?

Participant Demographics

The researcher recruited seven board-certified music therapists currently or formerly supervising music therapy students in the music therapy academic and clinical training program of a large Midwest university of the United States. Six of the seven music therapists who were contacted responded with interest and consented to participate in this research study. One participant did not respond to the invitation to participate (see Table 1).

Table 1

Semi-structured Interview Demographic Information

Participant	Age	Gender	Degree	Years as MT-BC	Years as MT Clinician	# of Semesters Supervising	Origins
A	32	Female	Doctoral	10.0	10.0	8	American
B	42	Female	Doctoral	14.0	14.0	2	International
C	24	Female	Masters	1.5	1.5	2	American
D	28	Female	Masters	5.0	3.0	6	American
E	47	Female	Doctoral	14.0	14.0	8	International
F	37	Female	Doctoral	11.0	5.0	6	International

Prior to experiences supervising music therapy practicum at the aforementioned university program, participant E had experienced supervising music therapy students at another university, participant F had previous experience supervising psychology and special education students while participants A, B, C and D did not have prior supervision experience. An interest in a helping profession that included medical or special education settings drew participants into the music therapy field. All participants had previous music training and learned about music therapy in high school. Before participants became clinical supervisors in the examined program,

they had various experiences working with different populations. Five participants indicated that they had experiences working with young children or school-aged children in either clinic, school, private practice or medical settings. Two participants had experiences working with adult with intellectual or developmental disabilities. One participant had experience working with adults with stroke; one participant had experience with older adults in the community. At least one of the six participants worked at a psychiatric hospital, domestic violence shelter or hospice agency. Additionally, one participant had experience working with a supervisor in a NICU and a cancer care center.

As for motivation to become a supervisor, all of the participants were graduate teaching assistants (GTA) in the program and supervising in music therapy practicum was part of the assigned responsibilities. One master's student further indicated that her interest in music education drew her to apply for the position. Four of six participants were doctoral students in the program and supervision was a requirement for their Graduate Teaching Assistantships. One of the doctoral students started to supervise when she was studying for her master's degree in the program and then continued as a doctoral student.

Interview Environment

Participants scheduled the interview location and time with the researcher via email or text. Once location and time of interview were decided, the researcher sent a preliminary introductory questionnaire through email to the participants. The researcher interviewed four participants in person; three met with the researcher on the campus while one participant met with the researcher at a coffee shop. The remaining two participants were not able to meet in person; therefore, the researcher conducted their interviews through Facetime and Skype.

Research Question

The semi-structured interview guide was established with seven different topics to determine content to provide answers for the primary research question: what is the process of clinical supervision for music therapy practicum from the perspective of the clinical supervisor? The participants did not merely provide answers when interview questions were targeting certain topics; information was also discovered about a single topic from responses to other questions during the interview.

Superordinate Themes

The researcher completed the data analysis from steps 1 through 5 and compiled twelve superordinate themes from the semi-structured interviews: (a) challenging supervisory experiences as a supervisee, (b) positive supervisory experiences as a supervisee, (c) challenging supervisory experiences as a supervisor, (d) positive supervisory experiences as a supervisor, (e) supervisor's own growth, (f) supervisory model/approach, (g) supervisory techniques and strategies, (h) personalization process, (i) reflective thinking, (j) different formats of supervision, (k) supervisory focus and (l) cultural sensitivity. The researcher discovered similar themes across interviews, with superordinate themes often intertwined with others. For example, to facilitate a supervisee's learning process in music therapy, supervisors need to make decisions how to personalize the process and techniques, strategies and formats grounded within their models for different supervisees. The decision-making process is based on supervisor's own growth and past experiences. The following superordinate themes were discussed and the quotes from the semi-structured interview were presented:

Challenging supervisory experiences as a supervisee. All participants had experienced being supervised as a student music therapist or as a clinician by professors, graduate teaching assistants, on-site music therapists or employers. They indicated that both positive and

challenging experiences were influential. The participants avoided providing the same challenging experiences for their current supervisee that they had suffered as a supervisee. Participants described various challenging supervisory experiences: Supervisors did not provide specific feedback which included either positive or constructive aspects; supervisors used similar supervision strategies for most of the supervision sessions; supervisors were not involved in the therapeutic relationship; supervisors had different philosophies than the supervisee; supervisors were not supportive or available, supervisors did not give examples or provide modeling nor did they provide regular supervision meetings. Participants described their challenging supervision experiences as a supervisee:

I felt very much like I was floating. Just disheartened cause I didn't know how to get people to participate. (Participant A)

...is an automatic breach of trust there. I tried to confide in you and you did not reciprocate my feelings at all, you made me feel ridiculous for thinking that, you make me feel dumb for thinking that.... (Participant C)

With the experience of having frustrations as a result of previous supervisory relationships, participants chose to use different approaches and techniques to address supervisory issues when they became a supervisor:

...there were a couple times when I felt the supervisor was being very judgmental and very punishing and giving me very harsh feedback without really trying to understand what I was trying to do...I committed myself to trying to understand where they're coming from and what they want to do before I pass judgement. (Participant E)

However, the challenging supervisory situation participants experienced as supervisee may still be difficult to address and change as they became a supervisor:

I think it's hard for me to even reach out to the person to talk about my problems...I think it's challenging if I don't know what's going on, you know if they are not willing to be vulnerable or they are not willing to be transparent about their experiences. (Participant F)

Positive supervisory experiences as a supervisee. In contrast to the avoidance of experiences with comparable challenging opportunities', participants tended to imitate the supervision approaches they had experienced as a supervisee. Supervisory techniques and perspective of the participants used currently in clinical supervision of practicum were learned from their best supervisors. They described that these individuals provided feedback that was specific and included both positive and constructive aspects, used modeling, gave appropriate tasks and taught them *how* to think not *what* to think. Their best supervisors were knowledgeable, experienced, encouraging, supportive, caring, dedicated, organized and inspiring. They listened from the supervisee's perspective, gave grace, validated concerns, "had a lot of humanity" (Participant C) and provided extra help. The supervisory relationship participants had with their own supervisors was collaborative where they were allowed independence and freedom for exploration.

When participants identified their own supervision strengths, approaches or techniques in response to later questions during the interview, they stated similar characteristics about themselves as those they described as attributes of their best supervisors:

I remember being acknowledged for all the things I was doing well...I think I am a really positive supervisor, I tend to try to let students know what they are doing well. (Participant A)

She would be very curious to know about clinical decisions. She would be available when I don't have to facilitate sessions. She would give me positive and constructive feedback...I usually start by keeping the conversation open, like what was your clinical experience like? How do you feel about the situation? I also think I am available...I usually leave my door open....(Participant F)

Two participants mentioned the importance of the supervisor being involved in the therapeutic relationship. In their current training program, client(s) typically had different student music therapists (supervisees) every semester, yet, could have the same supervisor across semesters. The supervisor built the relationship with the client and their families by participating

in the therapeutic environment which was in turn beneficial for student music therapists (supervisees) to learn how to maintain an on-going therapeutic relationship with clients.

Challenging supervisory experiences as a supervisor. Participants were asked about their most impactful challenging experience as a supervisee and their own challenges as a supervisor during the interview. The answers to both questions were related although the researcher asked the questions separately. Challenges in the supervisory experience were due to both the supervisees and supervisors. Supervisee's behavior, attitude toward the music therapy practicum and personality sometimes were difficult for the supervisor when facilitating the supervisees learning process in supervision as well as in an effort to maintain a positive supervisory relationship.

I had a really challenging student who was, how do I say this diplomatically? Manipulative, I think and tried to really (pause) really had a hard time with deadlines and they were never prepared and just (pause) It was just a struggle to also connect with them authentically. (Participant A)

They are not willing to talk about how to improve themselves or not willing to talk about what's really preventing them from moving forward. Those things can be personal I think like I said the issue can come from you know...personality. (Participant F)

It can be really hard in the moment when you feel you have done everything to prepare a person that they need to do more, and you know they are not, and you still keep pushing. (Participant D)

Challenges in the supervisory experiences were reciprocal such that supervisees' behaviors were influential to supervisors' behaviors and vice versa. From the supervisor's perspective, it was not easy to maintain a positive supervisory relationship when the supervisor believed that the supervisee did not have the personality to be a therapist, the supervisor felt incompetent dealing with a challenging supervisee, or the supervisor had to learn a new music therapy practicum system along with other supervisory tasks. One supervisor indicated that supervision is time consuming because the supervisors were responsible for observing the

session, conducting the supervision meeting and grading. Additionally, supervisor's personality also had a significant impact and could become a supervisory challenge:

I have little patience for dishonesty and I understand sometimes that students can just be dishonest because they are afraid of getting in trouble. But that really gets to me. I'm like No if you're going to lie to me, forget it, I'm not investing in you. (Participant E)

I love to control...that whole thing of letting them be self-efficacious and I might see that something is going to fall so flat. (Participant C)

Positive supervisory experiences as a supervisor. Supervisees making progress in their practica was rewarding for the supervisors. Participants indicated that they felt more comfortable, confident and competent as a supervisor when their supervisees had positive impactful experiences. These experiences included supervisees making connections or having meaningful moments with their clients; challenging themselves, developing autonomy, demonstrating trust in the supervisory relationship, appreciating their supervisor and moments when the supervisee was confident, showed potential and applied feedback to subsequent sessions. Participants were also graduate teaching assistants in the academic program, so they also thought it was important to see supervisees transfer the knowledge they learned in classroom lectures into their clinical practice.

...there was a little note written at the end of the year just saying that I was the one who genuinely cared about them as a whole person not just a student music therapist. So that was something that I left and I am like" ok, I think I at least can and did what I meant to do when I was here. (Participant C)

Supervision is hard. It's hard and it's also so rewarding, I think one thing that's fascinating about supervision is how much it affects clinical work afterwards you know...(Participant D)

Supervisor's own growth. The supervisor needed to make supervisory decisions regarding the model, process, formats and techniques to best facilitate the supervisee's learning process. Participants' own growth as a supervisor impacted what kind of supervisors they were

currently. The supervisor learned from both their experience as a supervisee as well as their experience as a supervisor. More specifically, they established their knowledge about supervisory approaches, formats and techniques from previous supervisors and grew more from the interactions with supervisees over the time they were in the program:

At the beginning especially, I was just trying to use the style my internship supervisor used. (Participant B)

The entire experience in supervision allows me to keep building ideas for modeling for the next students that were more effective. (Participant D)

Most of the participants took a supervision course before or during their first semester working as a clinical supervisor. The supervision course helped supervisors to advance their knowledge about supervision in music therapy such as supervision models and supervision techniques. The researcher, also a clinical supervisor within this program notes that the instructor of the supervision course required each new supervisor to observe other experienced supervisor in the program as models. The experienced supervisors were also invited to share their experiences and supervisory philosophy in the supervision class.

The book we use for the class had a Gestalt empty chair...switching the position between student and supervisor. So, a few times I asked my students to ask (questions) like a supervisor to kind of see things through a supervisor's (lens). (Participant B) *(This quote was slightly revised based on the feedback from member check.)*

Additionally, all of the participants were graduate students in the program so they were also taking graduate level courses. Participants indicated the influence of other courses on supervision, especially in supervisory model:

That's what I 'm working on. Throughout my doctoral life, I was acquainted with parent coaching....(Participant E)

The clinical supervisors in the associated academic and clinical program had a weekly meeting with faculty members in the program. When the supervisor had a supervisory issue, the faculty

provided guidance or engaged with them to address the issue as needed. How faculty members addressed supervisory issues was also a model for supervisors to learn from:

I had a really challenging student...I talked a lot with Dr. xxxxxxxx that semester and got her support, and felt really...really supported by everybody. (Participant A)

With different backgrounds, the participants mentioned that they applied the knowledge and skills they learned from their previous training as a clinician, educator or musician to their role as a supervisor in music therapy. Two participants who were international students and one participant who studied abroad indicated that their experience of getting training in a completely different culture sharpened their own skills of being culturally sensitive and enhanced their ability to teach supervisees to be culturally sensitive.

During participants' experiences, supervising students in the program, participants indicated that they often self-reflect as a supervisor and clinician. They became more convicted about their music therapy clinical approach, understood more about music therapy and learned from the supervisee's sessions.

Supervisory model/approach. The researcher prompted participants to describe their approach to supervision and asked them whether they approached clinical supervision from a particular model or orientation. The majority of participants described their approach as student-directed or student-centered while also indicating other models or orientations used collaboratively. Two participants identified themselves as selecting the best approaches from various resources and applying them to supervision:

I am eclectic...but I actually take a lot from my training as educator...and a lot of that spills over into supervision. (Participant A)

I do think it's very eclectic. You know mostly based on my prior experience with other supervisors that I had and not as much based on the particular theory. (Participant D)

Both the student-directed approach and the student-centered approach described by the participants shared the same essential factor: letting supervisees have a certain level of independence in both the therapeutic relationship and supervisory relationship:

I tried to let them kind of discover the best goals for their clients and the best way to meet those goals. (Participant A)

So, one was the student-centered approach of asking them to lead the conversation...having student to lead the conversation on what they need and what they want to focus on....(Participant D)

I try to make supervision experience really directed by students and sometimes having questions that really make them think, reflect on their clinical experiences rather than telling them what to do....(Participant F)

While the supervisors indicated allowing the supervisees to have freedom in their music therapy practicum, the balance of how much authority the supervisor should lend to the supervisory relationship is delicate. The balance of giving more freedom versus contributing more authority was based on the supervisor's perspective and the supervisee's behavior. When the supervisor chose to give less authority in supervision, she might struggle with holding the supervisee accountable. Supervisors indicated that they decided to become more direct and specific when the supervisee did not turn in assignments on time, apply supervisory feedback, or prepare for their sessions:

I was a little bit worried about like having authority, which is something just as a clinician too that I used to struggle with. (Participant A)

I have tried preventive measures more than in the previous session of, umm, like I was saying email and then first in correspondence: ok, this paperwork is not detailed enough, I can tell from looking at this that your plan is not fully ready, that you're gonna have to be making stuff up for adaptation. (Participant D)

Participants also identified behavioral, cognitive-behavioral, cultural-humanistic and humanistic models as additional models of clinical supervision in music therapy. With the behavioral or cognitive-behavioral supervision models, supervisors acknowledged the positive aspect of supervisees' performance in practicum and indicated areas that need improvement without

“sugar coating” the feedback. One of the supervisors who identified using a behavioral supervision model also ignored undesired behaviors such as making excuses for unfinished tasks or lying. However, all supervisors pointed out the importance of providing positive feedback in supervision even though some of them did not specify the behavioral model. Additionally, participants who identified the cognitive-behavioral supervision model also tried to provide guidance based on supervisee’s motivations in the supervisory and therapeutic relationships.

One participant described her model of supervision as the parent-coaching or adult learning model with the supervisee coming into practicum with knowledge and skills obtained from the classroom, so that the supervisor did not have to use authority to manage the supervisee:

...not being like a top-down supervisor, it’s more like I am going to coach you...I am going to be with you and walk side-by-side and try to understand. (Participant E)

Other participants also acknowledged that supervisors should recognize what skills supervisees already had when coming into practicum:

I try to...really think about what the supervisee is bringing to the table, I think when I first started in supervision it wasn’t that way. It’s really like, ok this is not the way only to be and we all are coming in on a similar blank slate. But we are not blank slates. (Participant D)

Three of the six supervisor participants identified that they implement supervision from a humanistic or a cultural-humanistic perspective. Other than role of being a student therapist in practicum, the supervisors were trying to see their supervisees as a whole person both in the clinic and outside of the clinic.

I want to approach them as an entire being because whether we like it or not, that is going to affect how they are providing services. (Participant C)

One of the six participants was not certain about the model or orientation she used in supervision but described her model as a supportive model:

I am not really conscious about a certain approach, but I don't know if supportive supervision is a model, but I will say my approach is a supportive supervision style. (Participant B)

Supervisory techniques and strategies. Participants identified several supervisory techniques and articulated how they used them in supervision when the researcher asked about them. However, when the researcher asked about the supervisory process, focus or challenges, participants also mentioned techniques and strategies in certain circumstances. Moreover, several participants who identified their supervisory approach as student-centered would also agree to use supervisory techniques to address supervision problems if the supervisee requested them to do so.

Giving feedback. During the supervision meeting after sessions, the supervisor gave feedback to the supervisee about their facilitation, musical skills and therapist effectiveness. Several participants mentioned providing detailed and specific instructions while giving feedback was critical for the supervisee to understand the supervisor's expectations. From their experience as a supervisee, most participants emphasized the importance of providing a gentle balance of positive and constructive feedback. The balance between giving positive and constructive feedback was based on supervisee's behaviors and personalities:

I'm behavioral, so I do believe in people changing their behavior, also their condition...I reward them a lot when they change their behaviors, or they do something better and I am not very...I don't put my attention into excuses or explanations. (Participant E)

I think it depends a lot on the personality of the supervisee. People are tougher and softer in difference places...If I can tell there is a lot of negative self-talk. I would like to provide as much unconditional positive regard as possible to them even if it's the smallest things like: Wow you tuned your guitar today. That's awesome. (Participant C)

The use of facilitating reflective thinking and giving feedback were often two sides of the same coin. The supervisors sometimes had to balance the use of these two techniques while sometimes incorporating the two techniques simultaneously:

There has to be a balance too of you telling and you asking. Can't all be asking, I think, that would just be too frustrating. (Participant A)

So, one was the student-centered approach of asking them to lead the conversation. I think its kind of overused now, but you know what are three things that you do well? what are three things you can improve upon? (Participant D)

Additionally, two participants shared that they also used preventive strategies while giving feedback to the supervisee before the session based on supervisee's session plan to ensure client's welfare:

I don't want my students to repeat the mistakes I made so I was able to give them some kind of cautions and warning before they even start sessions. (Participant B)

I have tried preventive measures more than in the previous session of, umm, like I was saying email and then first in correspondence: ok, this paperwork is not detailed enough, I can tell from looking at this that your plan is not fully ready, that you're gonna have to be making stuff up for adaptation. (Participant D)

Modeling. One participant specifically mentioned that she used modeling in supervision and during the interview. She identified modeling as her strength as a supervisor and indicated modeling was essential for the learning process based on her experience as a supervisee:

Try to do a lot of modeling and (pause) also as hands on as possible with the clients...I still feel like I need to be part of the therapeutic experience in a way since I do have a responsibility ethically to that client, so whenever possible I try to stay back and let the student really own the room and be the therapist in the moment but also have moments helping when necessary or just modeling a really positive therapeutic relationship with the clients. I had a client multiple semesters. I've already had that relationship modeling, you know, I can positively interact with that person for the student right off the bat. And helps them feel little less nervous too. (Participant D)

Another participant shared that she liked to be involved in the therapeutic relationship such as the interview process to establish a relationship with clients and their families. Although she did not identify it as modeling, the positive relationship established between the supervisor and the client and/or families could also be a model for supervisees to learn from.

Role playing. One participant identified using role-play during supervision to facilitate the supervisees' self-awareness:

...sometimes I made them recreate what they did during the session when they have a meeting with me so I would facilitate certain portion of their session and you know and that's the moment when they see themselves "Oh! Did I do that? Did I say that? Did I play music that way?" So, that's the moment that they learn by sort of going through the same thing that might not be the best choice at the moment they could make right. (Participant F)

Music Making. One participant shared about using music as a tool for supervision and stated that it was a good experience. The music making experience was requested by the supervisee of the supervisor who identified using student-centered approaches during the interview. The process of music making as supervision was also similar to the therapeutic intervention in the music therapy session.

We did (pause) like drumming together and I led the music-based experience because I was (pause) this request I was trying to address some of those stressors. I did identify as being negative and they identify some things, so things they identify as some things that were really preventing them moving forward or keeping them from making the best decisions, they could make so that was a moment. (Participant F)

Lecture. Group format of supervision was often utilized to address general issues happening to most of the supervisees in the clinical practicum settings. Participants described that they tended to plan a lecture targeting a topic and lead a follow-up discussion.

I'd almost lecture, maybe lead a discussion where I'd have some talking points planned, like "this happened a lot about termination." I would try to talk about termination in advance enough so that everybody could start thing about it and could ask their questions way before it was like, Oh, by the way, you have three sessions left and you haven't even thought about termination yet. (Participants A)

Peer support. Group supervision allowed the supervisor to facilitate peer support between supervisees to address clinical issues.

I tried to have them do a lot of peer feedback in group supervision, and we also did a lot of feedback on their written work, which was really nice – it turned out to be really beneficial. (Participant C)

I wanted them to start to assist each other and kind of do almost a peer supervision without having them directly go "Well I think you could do this better, I think you could do that better. I think you do this really well " but really

having that peer supervision being about "ok, what was your thought process behind this? Why did you think that was a good choice? (Participant A)

Personalization process. An interpretation of the supervisory process from the perspective of the researcher is that it was personalized by each supervisor. When the researcher asked about the supervisory process, two participants shared about their internal process being a supervisor, one participant shared about the supervisory process within a single supervision meeting and three participants shared about their supervisory process across the whole semester. For the two participants who talked about their internal process as a supervisor, one supervisor focused on the supervisee's perspective while the other supervisor focused on her own feelings for supervision:

It's an exciting type of wild. Because you get to watch students make discoveries and sometimes you can almost literally see neurons firing and making connections.... (Participant C)

I will say at the beginning of the fall semester supervision, it was (pause) I was stressed and (pause) but toward the end of the first semester I felt pretty good (pause) so in the second semester I think things got much easier and I was more comfortable grading their assignments....(Participant B)

As for the participant who talked about her supervision process within a single supervision meeting, she described her supervision meeting as asking reflective questions about her supervisees' clinical experience, thinking process and emotions attached to each session. During the supervision meeting, the participant also described the notes she took during the session, targeting areas needing improvement and discussed how she asked follow-up questions and summarized the to-do list when she closed the meeting:

I usually start by keeping the conversation open, like what was your clinical experience like? How do you feel about the situation? ...How did it go? Basically, a time to reflect on their feelings as I am sure they have some feelings attached to the way they facilitate their session...(Participant F)

The other three participants described their supervisory process across the whole semester, one participant indicated that she liked to be involved in the therapeutic process and

decided how to adjust the supervisory process based on the developmental level of the supervisee. One of the three participants specified that she believed the supervisory process was similar to “treatment” in music therapy and the third participant shared that she structured supervision in a similar way:

It’s very similar to the treatment in music therapy. I do think about as starting with an assessment...I asked them to write a goal for themselves throughout the semester...In the last session I would try to summarize the process for them and point to what I think they could work on for the next semester. (Participant E)

I like to start the beginning of the year with kind of an informal contract between myself and the supervisee. Starting out with a clear expectation from both sides....(Participant D)

However, all participants shared that the supervision model, supervisory approach and accompanying techniques in the supervisory process were also personalized to each supervisee. Supervisors adjusted their supervisory process based on supervisee’s personality, strengths and weakness, current concerns and questions and developmental level:

I think it depends probably on the student and the site. (Participant A)

So, it allows for some individuality because that’s another thing that’s very important in the supervisory process, because it’s very individual to individual you know...not just to have a cookie cutter way of supervising but based on what happens in the session. (Participant D)

Supervisors’ adjustment of the supervision process as related to supervisees’ developmental level was also queried during the interview by describing differences between first- and last-semester students. First-semester supervisees tended to focus on themselves instead of focusing on the client, struggle with finding resources and grapple with connecting interventions with theory and research. Additionally, first-semester students often “freaked out” about practicum, felt panicked, insecure, helpless, confused and lost or had false confidence at the beginning. Therefore, the supervisor often needed to help first-semester supervisees shift from self-focus to the external environment, used gentler approaches when students were feeling

vulnerable and redirected the student to focus on the big picture rather than details. Hands-on assisting, being more directive, coaching and providing concrete guidance were more appropriate for supervisees who felt confused and lost. Comparatively, last-semester supervisees needed deeper questions for internal reflection, were able to answer questions and work on overarching goals with their supervisors while able to identify needs and strengths, possessed the ability to tie their treatment to a strong rationale, demonstrated self-awareness and exhibited advanced techniques. The supervisory relationship became more student-lead and collaborative:

...like first-semester really hands on and I also probably had to really be like a lot more of like a cheerleader, like, you're doing fine! You can do it! (Participant A)

First-semester student...putting into practice all that they've been learning and getting out of their own head. They are so focused on themselves, on doing the right thing. Am I playing correctly? Am I doing....(Participant E)

Last-semester student: I feel like they have a pretty good understanding about the verbal process. The process of change that includes therapeutic process, includes documentation...they kind of know how to use the clinical language. (Participant F)

Last-semester student: I think you are able to start getting into more of those deeper questions that more internal reflection about, ok, what am I doing here? Why am I doing it? Some of them are ready to do it from the get-go. (Participant C)

In addition to supervisory process, the participants described the supervisory relationship as pretty close and intimate: a coaching interaction, a therapeutic relationship like between client and therapist, a collaborative relationship and a friendly relationship. Four participants mentioned the importance of mutual respect, trust and honesty in the supervisory relationship:

We are not equal, we have different roles that we bring into the session and I try to respect their idea that I have never done, but if I think it's reasonable and well-argued and well-document then I'm like, "Go for it." (Participant E)

I like to share, I disclose things to my students about my learning process as a student, or as a therapist, some of my weaknesses because I think that helps them see me in a real light. (Participant A)

I would like to believe like trust is important. They have to trust me that I have some answers to their questions. Trust me that I am here, I am willing to help them (Participant C)

Boundaries in the supervisory relationship were also considered essential. By setting up clear expectations — such as with the means of communication — at the beginning, both the supervisor and supervisee could have a better understanding of their responsibilities:

I would say we had a friendly relationship but of course I kept the appropriate boundary so they are not...my students are not my friends. (Participant B)

It has to be established at the beginning with certain boundaries and guidelines, but it's also built on trust and trust which comes through clear expectation like I mentioned with everyone doing their part. (Participant D)

Reflective thinking. All participants used reflective thinking as a technique to facilitate supervisee's thought process during supervision. The supervisor encouraged the supervisee to reflect on themselves, on client's behavior and on the intertwined connection between themselves and their clients by interjecting probing questions during supervision:

I ask a lot of questions. I'm not sure if that's a technique. I asked like questions, I asked him to self-reflect in the moment so, tell me about this and why did you do this? What do you think about that? (Participant E)

I like a lot of introspective thinking from my student, asking them *why* a lot and I really like the idea of silence and not necessarily filling that with anything. If I can tell they are waiting for me to have a response, just shutting my mouth and see what comes out of theirs instead. (Participant C)

I first ask my students questions, how the session went (pause) and then give them more specific questions. (Participant B) (*This quote was slightly revised based on the feedback from member check.*)

Different formats of supervision. The researcher asked about participant's experience of using different supervisory formats in the program giving three primary examples: individual, triad (two supervisees and one supervisor) and group supervisory format. Due to the clinical placement in the program, inexperienced students (supervisee) were paired with an experienced

peer for the practicum experience in a dyad. The experienced students would typically have one placement collaborating with a novice student and one placement facilitating the session independently during the same semester. Therefore, all participants had the experience of supervising students in individual and triad supervision formats.

One participant believed that there were no differences between individual and triad supervision formats, while other participants indicated that every format was different with varied advantages and disadvantages. Five of the six participants indicated that in addition to using individual or triad supervision formats, they also used group supervision format meetings with all of their supervisees at the same time.

Individual format. Within the individual supervisory format, the supervisory process was more supervisee-focused. The supervisor could work on specific and personal supervisory issues within this context.

I would focus a lot on the person and we could probably dig deeper into their needs and chat and challenges and be more well honest about what they're going through. (Participant E)

With an individual it's a lot easier to look at the overall skills of the student and talk more in depth about specific moments tied to progression of the student skills. (Participant D)

Triad format. With the triad format, the supervisor often encouraged supervisees to provide feedback for each other during supervision. Maintaining positive relationships with their peers was also a learning process for the supervisee; therefore, the supervisor sometimes needed to provide guidance to facilitate collaborations. One participant also mentioned that the supervisee can request an individual meeting with the supervisor if they wanted to:

Dyads are a lot different and I felt like my role as a supervisor is a little more removed because they give each other feedback, and in some ways it's lovely and in other ways you can make students who make these decisions like, "What? What have you decided to do that?" You feel left out as a supervisor, and maybe they're pushing ahead and you're like "Woah, can we go back to the beginning

and not make that decision? (Participant A) (*This quote was slightly revised based on the feedback from member check.*)

The dyad I had to be a lot more careful in giving enough time to both of them and being able to not be making either one feel bad in front of the other. (Participant E)

Group format. Within a group supervision format, the supervisory process was usually more client-focused than therapist-focused (supervisee-focused). One participant indicated that group supervision was more time-efficient but needed more preparation before and more management during the supervision. Participants facilitated the group supervision with specific goals such as working on general issues that applied to every supervisee, providing a stage for supervisees to “perform” musical skills, connecting supervisees that had worked with clients previously or giving lectures and/or facilitating discussions on a specific topic. One participant shared that she gave prompts at the end of the group supervision for the next supervision:

Definitely different, I tried to have them do a lot of peer feedback in group supervision and we also did a lot of feedback on their written work...also I think I did more music skills in group because they had people, to “perform” it for. (Participant A)

I want them to answer the question for each other...kind of do almost a peer supervision. (Participant C)

I eventually ended up doing group supervision for the more general things, so that things that apply to everybody: How do you choose treatment? How do you do assessments or the forms that you use? (Participant E)

Supervisory focus.

The participants were asked about their supervisory focuses during the interview guide; however, the participant also provided information about what supervisory issue they would prioritize during the supervision meeting while answering other questions. Because the supervisors often allowed the supervisees to lead the conversation during the supervisory process, the supervisors focused within a single supervision meeting were sometimes decided based on supervisees’

requirements. The supervisory focuses were described by the participant throughout the interview include musical skill, therapist effectiveness and professionalism:

Musical skill.

How do I prioritize thing they need to work on (pause) because there can be ten different things they need to work one right. Well I think musicality is the most confronting right ? as they are struggle with their musicianship skills...they are not gonna be able to focus on their client right? Music seems to be an element that really goes on the bottom. Likes here's a thing you have to fix right now if you can't sing you know in tune then (laugh) you are in trouble. (Participant F)

Therapist effectiveness. Besides focusing on sessions, two participants directly indicated that they worked on verbal processing and interpersonal skill during supervision:

I also just really love working on interpersonal skills. And so, if the music was fine, it was like it just kind of stayed fine. I really loved focusing on some of those skills, partially because they don't get that in a ton of their classes. (Participant A)

...verbal processing skills I guess comes next (pause) sometimes they don't know how to ask questions. Sometimes they don't know how to come up with appropriate question (Participant F)

Professionalism.

Well it depends. Well, obviously, the ultimate goal is to give the client the best service. So that's obviously at the forefront. What does the client need and is my student meeting that need? So, if the student is not meeting that need what do we need to do to help her to meet that need?

Cultural sensitivity. Most participants did not have experience supervising international students in the program. The participants stated that they would not use different supervisory approaches or techniques if they had an opportunity to supervise international students, but they would be cautious about language barriers:

...if there is a language barrier which hasn't really been my experience in the supervision, but I try to start with knowing that could be the case. (Participant D)

The only adaption I guess is that I'm more careful about my language, so I'm careful not to use slang. I'm careful not to use very colloquial expressions. (Participant E)

All three participants who were international students received their music therapy training in the United States and described that they self-disclose their own experiences as international students when they have international students as supervisees. Most participants believe international and domestic students were similar, the difference was based on their personalities rather than cultural differences. Only a few differences between international students and domestic students were brought up; for example, international students were more respectful to older adults, which sometimes limited their capacity to facilitate sessions.

Four participants shared that cultural sensitivity was not emphasized in either the therapeutic relationship or supervisory relationship at the time when they were supervisees. Two of three participants who were international students expressed they had experiences of not being understood because of culture differences with a previous supervisor.

The following table was summarized from the discussion of each superordinate themes to provide a comprehensive description:

Table 2.

Superordinate Theme

Superordinate Theme	Description
Challenging supervisory experiences as a supervisee	Participants avoided providing the same challenging experiences for their current supervisees that they had suffered as a supervisee.
Positive supervisory experiences as a supervisee	Participants tended to imitate the supervision approaches they had experienced as a supervisee. Supervisory techniques and perspective of the participants used currently in clinical supervision of practicum were learned from their best supervisors.
Challenging supervisory experiences as a supervisor	Challenges in the supervisory experience were due to both the supervisees and supervisors. Sometimes the effectiveness of supervision was difficult to maintain because of the challenges <ul style="list-style-type: none"> • Supervisee's behavior, attitude and personality • Supervisors felt incompetent, had to learn a new music therapy practicum system along with other tasks, felt

	supervision was time consuming and their approach had to differ based on their own personality.
Positive supervisory experiences as a supervisor	Supervisees making progress in their practica was rewarding for the supervisors. Participants indicated that they felt more comfortable, confident and competent as a supervisor when their supervisees had positive impactful experiences.
Supervisor's own growth	Supervisors needed to make supervisory decisions regarding the model, process, formats and techniques to best facilitate the supervisee's learning process. Participants learned from: <ul style="list-style-type: none"> • Experiences as supervisee • Experiences as supervisor • Related professional training • Graduate level courses • Faculty support
Supervisory model/approach	The supervisor incorporated different models/approaches in supervision. Participants identified student-centered, humanism/cultural humanism, behavioral/cognitive behavioral and parent coaching.
Supervisory techniques and strategies,	Participants identified they implemented different techniques to address different supervisory issue: <ul style="list-style-type: none"> • Giving feedback • Modeling • Role playing • Music making. • Lecture • Peer support
Personalization process	Supervisors adjusted their supervisory process based on supervisee's personality, strengths and weakness, current concerns, questions ,and developmental level.
Reflective thinking	Participants used reflective thinking to facilitate supervisee's thought process during supervision. The supervisor encouraged the supervisee to reflect on themselves, on client's behavior and on the intertwined connection between themselves and their clients by interjecting probing questions during supervision.
Different formats of supervision	Participants utilized different supervision formats: individual, triad and group supervision to address different supervisory focus.
Supervisory focus	Participants indicated they addressed musical skills, therapist effectiveness and professionalism as foci during supervision.
Cultural sensitivity	Although not all had direct experience, participants described the supervision approach, techniques and formats they used for international student was or would be the same as domestic student, however, they were more aware of the language barriers when providing feedback.

Chapter 5: Discussion

Aim of the IPA

The aim of this IPA was to explore the process of clinical supervision for music therapy practicum from the perspective of clinical supervisors. The researcher addressed seven research questions through a semi-structured interview process, targeting eight primary topic areas. From the information gathered from these interviews, the researcher ascertained initial emergent themes and then 12 superordinate themes indicative of the supervision process for music therapy clinical practicum.

Superordinate Themes

To provide effective supervision and establish a supervisory relationship, supervisors make decisions to personalize the supervisory process based on the needs of their supervisees. Supervisor's positive and challenging experiences as both a supervisee and supervisor are impactful in the supervisory decision-making process. With the integration of a supervision model such as cognitive-behavioral, behavioral, student-centered or humanism, supervisors use techniques such as reflective-thinking, modeling, role-playing or music-making to address different issues related to the growth of the supervisee within a personalized process. Twelve superordinate themes emerged from the analysis of the interview transcripts. They are presented below in Table 2. I was inspired by the visual figure Liberman (2016) used to illustrate the relationship between themes that facilitate safety and trust in supervision. The purpose of choosing the tree was to symbolize that supervision provides support for supervisee's development. A tree was also chosen as it depicts growth from a seed to a full flowering plant just as the process starts with the lived experiences of a supervisor and blossoms into a supported supervisory process intended to most fully impact supervisees. Therefore, I chose to present the relationship between the 12 superordinate themes by illustrating a visual of a tree. The function

and role of the various parts of the tree were easy to understand and may present a clear representation of consequential elements for supervision training in the future.

The following visual figure (See Figure 1) demonstrates the relationship among superordinate themes that may support both linear progression and connectivity among themes. In addition to the representation of the 12 superordinate themes, sun and soil were also presented in this figure. Sun and soil provided necessary elements for the tree to grow. These embedded elements of supervisor's growth are a graduate level supervision class, related professional training and faculty support. These elements are impactful for the supervisory decision-making process so are included in the figure.

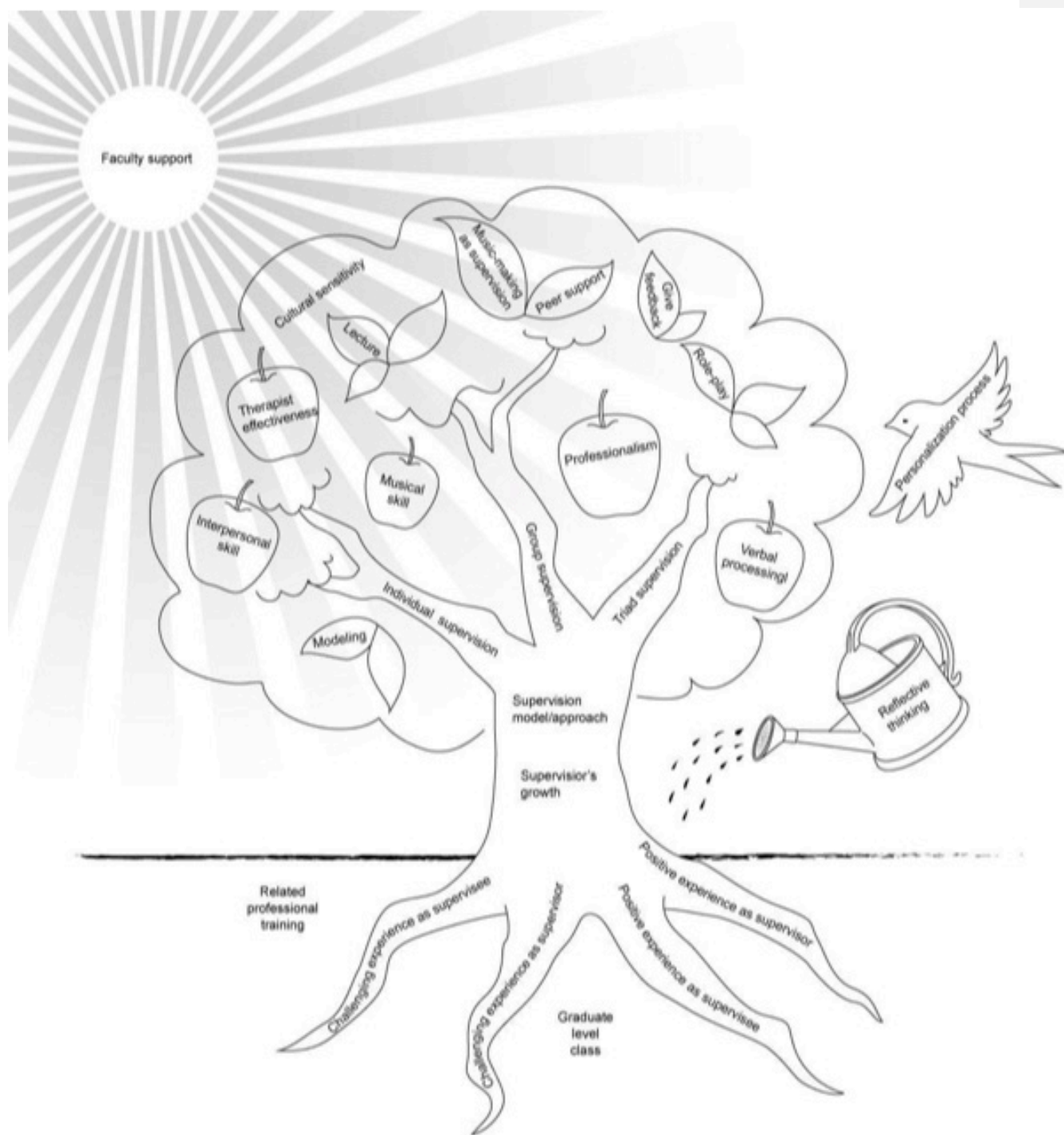


Figure 1. Visual Representation of the Superordinate Themes as discovered from the IPA

Table 3.

Superordinate Themes as Depicted in the Visual Representation

Image	Superordinate Theme	Description
Root	Challenging supervisory experiences as a supervisee	Challenging supervisory experiences as a supervisee are the foundation of the tree to support growth. The root also collects nutrients from the soil and stores them. It represents the supervisor gaining sustenance from a graduate level supervision class, faculty support and related professional training.
Root	Positive supervisory experiences as a supervisee	Positive supervisory experiences as a supervisee are the foundation of the tree to support growth. The root also collects nutrients from the soil and stores them. It represents the supervisor gaining sustenance from a graduate level supervision class, faculty support and related professional training.
Root	Challenging supervisory experiences as a supervisor	Challenging supervisory experiences as a supervisor are the foundation of the tree to support growth. The root also collects nutrients from the soil and store them. It represents the supervisor gaining sustenance from a graduate level supervision class, faculty support and related professional training.
Root	Positive supervisory experiences as a supervisor	Positive supervisory experiences as a supervisor are the foundation of the tree to support growth. The root also collects nutrients from the soil and store them. It represents the supervisor gaining sustenance from a graduate level supervision class, faculty support and related professional training.
Trunk	Supervisor's growth	Supervisor's own growth is the trunk of the tree. It supports the shape of the tree as well as transfers nutrition to the branches. It represents the supervisory decision-making process as established by previous experiences and new and on-going growth.
Upper Trunk	Supervision model/approach	Supervision model/ approach is the upper trunk of the tree. It supports the shape of the tree as well as transfers nutrition to the branch. The upper trunk also supports and determines how the branches grow. It represents how the supervisory process is grounded by the supervision model/approach.
Leaves	Supervisory techniques and strategies	Supervisory techniques and strategies are the leaves of the tree. The supervisor may implement different techniques and strategies through different formats

		(branches). The leaves transfer the energy into food for the tree. The food for the tree supports the growth of the tree as well as the fruit that the tree bears. This represents how supervisory techniques and strategies assist the growth of fruit (supervisor focus) and the sustenance of the tree (as the supervisor gains more experiences).
Crown of the Tree	Cultural sensitivity	Cultural sensitivity is the crown of the tree. The crown of the tree includes the leaves, the fruit, the branches and the upper trunk. Cultural sensitivity should be considered during and when using all supervisory techniques, foci, formats and models.
Watering Kettle	Reflective thinking	Reflective thinking is represented by the watering kettle at the side of the tree. The watering kettle provides water to the entire tree, individual or groups of components of the tree as needed. It represents how both the supervisor and supervisee can benefit from reflective thinking.
Branch	Different formats of supervision	Different formats (individual, triad, group) of supervision are the branches of the tree that are individualized yet can be connected. The branch of the tree provide support to the leaves and the fruit as well as stores water and food. It indicates that the supervisor may use different formats of supervision based on the needs of the supervisee. Each format has advantages and disadvantages with various techniques and strategies integrated within the formats.
Fruit	Supervisory focus	Supervisory focus is the fruit of the tree. The tree provides nutrition for producing this fruit that in turn provides sustenance for the growth of others (the supervisees. It represents that the supervisor facilitates the learning process with different supervision focus (i.e., professionalism, musical skills and therapist effectiveness). Different supervisory foci can be addressed within different supervisory formats.
Bird	Personalization process	The personalization process adapted by the supervisor is represented by the bird next to the tree. It symbolizes how the supervisor provides supervision through adjustment based on supervisee's needs and must be flexible and adaptable based on various considerations.

In addition to this personalized process represented in the above figure and while not aspects within the superordinate themes, mutual respect and trust are critical to establish rapport

in the supervisory relationship. Most of the interviewed supervisors arrange group supervision in addition to providing individual or triad supervision after the session yet each format has advantages and disadvantages. However, the researcher discovered that supervisors articulated that supervisees' personality characteristics and behaviors and supervisor's disclosed personal perspectives are also influential in the supervisory relationship, although not specifically targeted predetermined topics embedded in the interview. In the following sections, the researcher explored these issues describing the impact of supervisee's personality characteristics and behaviors and supervisor's own perspective in the supervision process.

Impact of Supervisees (personality, behaviors, potential)

Although the supervisor's background and experiences are significant for supervisory decision making, participants indicated that supervisee's personality, behaviors and academic and clinical potential are also substantial factors. Supervisee personality may factor into whether a positive supervisory relationship can be established or not, as well as factor into the quality of that relationship. Supervisors may sometimes struggle with certain personality types or characteristics due to their own personality traits; in such cases, the supervisory relationship may lack mutual trust and respect. Most of the supervisors indicated that they use student-centered approaches and allow supervisees to be independent. However, supervisees may sometimes demonstrate unprofessional or irresponsible behaviors such as manipulation or dishonesty, which decreases the willingness of supervisors to invest in the supervisee. Not only do the personality characteristics and behaviors of the supervisee influence the supervision process, but the academic and clinical potential of the supervisee also impacts the process and accompanying relationship. Supervisee potential could include skills they come in to clinical practicum with and/or professional judgement from the supervisor on future abilities. Supervisors' judgment

about supervisees' potential may also be based on personality characteristics and behaviors and as such is connected to the previous issue.

Impact of Supervisors' Personal Perspectives and Qualities

In addition to the supervisory model, techniques and format, supervisor's personal perspective is influential in the supervisory relationship. Analysis suggests that clinical supervisors apply their personal perspective as a therapist and educator into supervision, which is then intertwined with the clinical supervision decision-making process. With the goal of facilitating development of autonomy in supervisees in an effort to become effective music therapists, two supervisors indicated the significance of teaching supervisees how to think instead of telling them what to think. Furthermore, one supervisor mentioned that the supervisor has to help supervisees develop their own style rather than duplicating that of their supervisor. Accordingly, supervisors aim to cultivate supervisees' abilities to make effective independent decisions. In addition to facilitating decision-making and autonomy of their supervisees, supervisors face a similar dilemma which has a role in the supervisory process. Supervisors themselves often experience the challenge of trying to balance among providing effective supervision, maintaining client's welfare, all while following specific clinical training guidelines presented by the academic program.

Several supervisors stated that the supervisory relationship is similar to the therapeutic relationship, such that similarities with empowerment in therapy and the autonomy-facilitation in supervision are relatable and observable. The World Health Organization (2010) indicates that *empowerment* involves self-reliance, participation in decisions, dignity and respect and belonging and contributing to a wider community in the promotion of mental health. The National Empowerment center (2018) also defines "having decision making power", "having access to information and resources", and "learning to think critically" as qualities of

empowerment in mental health services. The use of empowerment is also discussed for educational and supervision purposes by McWhlrter (1991) and Holloway and Wolleat (1994). Holloway and Wolleat (1994) believe that supervision is not effective if the supervisee depends solely on the supervisor's skill, knowledge and expertise. To summarize, a supervisor's intention while making decisions corresponds to the personal qualities of empowerment as well as the instilling of those qualities in their supervisees. Still, some supervisors may choose to be specific about prompting what to do and what to avoid instead of allowing their supervisees to make independent clinical decisions.

Based on the semi-structured interview, supervisors identified qualities or characteristics they personally demonstrate in supervisory relationships. One example: never making assumptions when supervisees make mistakes and instead trying to first understand from their supervisees' perspective before passing judgment. Supervisors feel it is important to respect their uniqueness and provide genuine care which is correlated with the humanistic model that was identified during the interviews. Additionally, supervisors indicated that they want to exhibit the qualities of being communicable, available, supportive and encouraging to their supervisees.

Linguistic Elements in the Semi-structured Interview

Linguistic elements (see IPA step 2) during the IPA process were not as readily addressed within the results section as descriptive and conceptual comments. The current researcher-investigated topic of clinical supervision in music therapy did not trigger strong emotional reactions during the interviews. All participants remained relaxed with a calm tone of voice and a positive affect, typically with a smile on their faces while answering questions. One participant changed her tone of voice into slightly more excited, higher pitch when she described her inner voice during the supervisory process. Participants also tended to take a pause or laugh when they tried to recall a memory or tried to articulate a thought. In addition, two participants showed

more assertive body language by tapping the table using their hand when they were describing the authority aspect in the supervisory process. Three of the participants had first languages different than English and as such, some of their transcripts and subsequent included quotes were not always grammatically correct within the English language.

Implication for Music Therapy Supervision Process

The purpose of this study was to understand clinical supervision in music therapy from the perspective of clinical supervisors; moreover, to provide insights for clinical supervisees, potential and current supervisors and faculty educators. To complete the requirements under AMTA (see the Professional Competencies) to be qualified to take the board-certified exam, receiving initial training in supervision is common while training at the graduate level is somewhat imperative. Clinical supervision in music therapy training is consequential for supervisors to facilitate the learning process of musical skills, clinical foundations, inter and intrapersonal skills, therapist effectiveness and professionalism. However, the researcher was only able to locate limited studies targeting supervisees' perspectives in clinical supervision during pre-internship training (Hanser, 2001; Summer, 2001; Wheeler, 2002; Wheeler & Williams, 2012). For supervisees, this study is helpful for understanding a supervisor's intentions and expectations; whereas, for potential supervisors, this investigation may be helpful for understanding the possible challenges of supervising with an academic training program that is barely mentioned in existed literature. For current supervisors, the investigation may be helpful for understanding and learning from other supervisor's lived experiences targeting the many facets of the clinical supervision decision-making process. For educators, this study provides content for training, in-servicing and supporting clinical supervisors primarily because no studies focusing on supervisor's training in academic institutions was discovered by this researcher.

Limitations

This study employed interpretative phenomenological analysis (IPA), using semi-structured interviews to collect data from six participants recently or currently supervising in the same music therapy program. Statistics reporting supervision in a four-year academic institution is unknown; therefore, the researcher is not able to directly compare the demographic sample of this study with the demographic profile of practicum supervisors in the United States. All participants self-identified as female; according to the most recent Workforce Analysis (American Music Therapy Association, 2017), there are 10.58% music therapy professionals who identify as male, 0.21% as transgender and 1.09% as gender queer/gender nonconforming and different identifier (p. 9). In addition to gender considerations, three of the participants were Caucasian, two Asian and one Hispanic, however, 87% of music therapy professionals identify as White/ Caucasian/ European, 4.7% as Asian and 2.4% as Hispanic based on the ethnicity report from the Workforce Analysis (American Music Therapy Association, 2017). The sample of this current research study does not appear truly representative of gender or ethnicity.

The targeted environment of this study is a music therapy program in a large university in the Midwest. However, many other music therapy programs in the United States or outside of the United States may have different training elements such as the ratio of supervisor to supervisee and the professional role of supervisors (graduate student, full-time community-based clinician or faculty member). The result of this study may be not applicable for all clinical practicum training programs in music therapy.

Delimitations

The purpose of this research was to explore clinical supervision process in music therapy practicum from the perspective of the supervisor. In order to obtain these lived experiences thoroughly, the researcher chose to investigate solely from the supervisor's perspective by

conducting an interview instead of examining supervisee's perspective concurrently. In addition to pursuing profundity through this study topic, the researcher also wanted to narrow a gap in the music therapy supervision literature, which rarely focuses beyond the supervisee.

Although there were valuable research studies about clinical supervision from other fields such as music education or physical therapy, the researcher reviewed the literature from music therapy, counseling, speech language-pathology and nursing to study the supervisory techniques, models and formats used in each field. These additional health professions shared similarities with music therapy for the populations served, therapeutic goals and training program requirements.

Interpretative phenomenological analysis (IPA) allows the researcher to investigate the particular experiences by conducting an interview. The researcher used semi-structured interviews as the data collection tool, which allowed the researcher to build rapport and understand the participant's world more thoroughly (Smith et al., 2009). Based on the result of data analysis, the researcher tried to make sense of participants' lived experiences by interpretation with researcher's perception objectively presented. However, instead of pursuing a quantitative data analysis, both participants' and the researcher's sense-making process were important (Smith et al., 2009). The researcher of this study also had experience recently supervising students in the same training program, therefore, the researcher must differentiate her own experiences from that which was reported during interpretation.

Implication for Future Research

Results of this study present the lived experience for music therapy supervision from the perspective of supervisors. However, the supervisory relationship is actually established between a supervisor (experienced individual) and supervisee (inexperienced individual). According to the World Federation of Music Therapy in 2016, 76 schools provide music therapy academic and

clinical training programs in the United States. Future research should target an in-depth exploration of supervisees' sense-making process and lived experience in clinical training in music therapy. Wheeler (2002); Wheeler and Williams (2012) explored student's thoughts, feelings, concerns and experiences in music therapy practicum. Additionally, Abbott (2017) observed student's practicum logs to identify music therapy teaching and learning concepts. However, research studies targeting supervisee's sense-making processes when receiving supervision as a result of supervisor's decision-making processes are not sufficient. Possible foci could include: When and why do supervisors decide to use role-playing (or a myriad of other techniques) in supervision to address issue? How does a supervisee make sense of the supervisory relationship and process? How does this compare to the comparable perspective of the supervisor? Supervisory techniques, formats and model are often adapted from other health professions; yet, effectiveness of using these techniques, formats and model in music therapy supervision is unclear due to a dearth of research. In addition to conducting an interpretative approach study and investigating further topics in supervision, the current research could also assist and inform in a survey formula to study a larger sample in the future to understand more about supervisor's perspective in music therapy.

Conclusion

The current study explored clinical supervision in the music therapy training program at a large Midwestern University from the perspective of the supervisor. Clinical training accompanied with supervision from a board-certified music therapist before the music therapy student is eligible to sit for the board-certified exam was required. While previous researchers have studied supervision in music therapy from different vantage points, there has been no study focused on supervisor's perspective using an Interpretative Phenomenology Analysis (IPA) in pre-internship training. By conducting a semi-structured interview, the researcher investigated

supervisor's sense-making process targeting different topics. Twelve superordinate themes were determined from emergent themes based on the result of data analysis utilizing IPA: challenging supervisory experiences as a supervisee, positive supervisory experiences as a supervisee, challenging supervisory experiences as a supervisor, positive supervisory experiences as a supervisor, supervisor's own growth, supervisory approach, supervisory techniques and strategies, personalization process, reflective thinking, different formats of supervision, supervisory focus and cultural sensitivity. Supervisors made supervisory decisions to facilitate supervisee's most effective learning during practicum. Based on previous experiences as a supervisee and a supervisor, the supervisors personalized the supervision process as needed with different strategies and techniques, models and formats. Both the supervisor's own perspective and the supervisee's behaviors, personality characteristics and perceived potential had a role in the supervisory relationship and the supervision process.

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Appendix A

Recruitment Email

Research study: An interpretative phenomenological analysis study of music therapy clinical supervisors

Dear music therapy supervisor,

You are being invited to participate in an individual interview discussing your experience as a supervisor of supervisees in music therapy practicum.

To participate in the study, you must be at least 21 years old and have experience supervising practicum students at the University of Kansas.

To participate, you are expected to attend an individual interview with the researcher. The interview will take approximately 45-60 minutes to complete. The location of individual interview may be accommodated based on participants availability. These locations might include: in a classroom, office, or research lab of Murphy Hall on the campus of the University of Kansas, via skype/or facetime, or in a mutually agreed upon and appropriately private location off the KU campus. A member check will be asked by having you to review and approve any quotes will be used in the study via email after the completion of data analysis.

Although participation may not benefit you directly, we believe that the information obtained from this study will help us gain a better understanding of the practice of clinical supervision in music therapy from the perspective of the supervisor.

The content of the interview questions should cause no more discomfort than you would experience in your everyday life. It is possible, however, with internet communications, that through intent or accident someone other than the intended recipient may see your response. The information obtained from the interview will not be disseminated through internet communication. Each participant will be assigned an alphabet as pseudonym to maintain the confidentiality.

If you are interested in and willing to participate in this study or if you have any questions regarding the study, please contact Wei-Hsuan Tu at w402t330@ku.edu, or Dr. Colwell at ccolwell@ku.edu

Appendix B

Information Statement

Information Statement

An interpretative phenomenological analysis of music therapy clinical supervision process

Introduction

The Department of Music Education and Music Therapy at the University of Kansas supports the practice of protection for human subjects participating in research. The following information is provided for you to decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time without penalty.

Purpose of the study

We are conducting this study to better understand the clinical supervisory process of music therapy practicum from the perspective of the supervisor.

Procedure

You will be asked to participate in an individual interview with the researcher. Your participation is expected to take approximately 45-60 minutes to complete. The individual interview will be conducted on the campus, off campus or through an online video communication software to accommodate the availability of the participants. You will be asked to answer the questions from following areas:

1. Supervisor's background
2. Clinical supervision experience as supervisee
3. Clinical supervision experience as supervisor
4. Clinical supervision model
5. Clinical supervision process
6. Clinical supervision method, techniques and strategies
7. Clinical supervision Format, Assignment, and Behavior/ Changes
8. Culture awareness and sensitivity in clinical supervision

You will be asked to confirm and review any quotes used in the study for member check after the completion of data analysis through email. If you prefer to have a member check meeting in person, the researcher will schedule a face to face meeting. The locations will be in a mutually agreed upon and appropriately private location on or off the KU campus.

This interview will be recorded. Recording is required to participate. You may stop the recording at any time for any reason. The recordings will be transcribed by the researcher or a hired individual into an electronic file and hardcopy for data analysis. Only I, the investigator, the faculty supervisor, and a hired individual for assisting the transcribing will have access to the recordings which will be stored on an external flash drive. The link of between the participants and the interview transcriptions will be destroyed in one year.

Benefit

Although participation may not benefit you directly, we believe that the information obtained from this study will help us gain a better understanding of the practice of clinical supervision in music therapy from the perspective of the supervisor. Your participation is solicited, although strictly voluntary.

Participants Confidentiality

Your name will not be associated in any way with the research findings. Your identifiable information will not be shared unless (a) it is required by law or university policy, or (b) you give written permission. Only I, the investigator, and the faculty supervisor will have access to the identifiable information. You will be assigned an alphabet letter as a pseudonym when researcher report the result of the study to maintain confidentiality.

Risk

The content of the interview questions should cause no more discomfort than you would experience in your everyday life. It is possible, however, with internet communications, that through intent or accident someone other than the intended recipient may see your responses.

If you would like additional information concerning this study before or after it is completed, please feel free to contact us by phone or mail.

If you have any additional questions about your rights as a research participant, you may call (785) 864-7429 or write the Human Subjects Committee Lawrence Campus (HSCL), University of Kansas, 2385 Irving Hill Road, Lawrence, Kansas 66045-7563, email irb@ku.edu.

Sincerely,

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Appendix C

Preliminary Questionnaire

Thank you for kindly participating in this research. The purpose of this study is to investigate the experience of clinical supervisor in the music therapy practicum. Your answers are important to our study, and will be used to support the data analysis of the interviews. There is no right or wrong answer for the following questions. You can complete the questionnaire by typing or handwriting. Please fill out the questionnaire before the interview and bring a hard copy with you to the interview. If you have any question about questionnaire, please do not be hesitant to contact the researcher.

Demographic

- What is your age? _____
- What is the highest education degree or level of school you have completed? _____

- How long have you held the MT-BC credential? _____
- How many years have you been in the music therapy field as a clinician? _____
- How many semesters have you been a clinical supervisor for music therapy practicum at the University of Kansas ? _____
- How long have you been a clinical supervisor before you became a clinical supervisor for music therapy practicum at the University of Kansas? _____

Supervisor's background

- What drew you to the field of music therapy?

- Please describe your experience as a clinician since completing your academic and clinical training.
- How did you become a clinical supervisor?

Appendix D:

Semi-Structured Interview Guide

Pre-interview statement:

Thank you for your interests in participating in this research. The purpose of the research is to understand the clinical supervision process in the music therapy practicum from the perspective of clinical supervisor. The interview will be held from 45 to 60 minutes. The interview will be audio recorded. During the interview, you have the right to stop the recording anytime without giving the researcher any reason. You can also choose to not answer a question.

*The researcher will ask the questions with green highlight primarily, the questions with yellow highlight will be asked only when the time of the interview is sufficient.



Topic	Interview Question	Example Prompts as Needed for Extension
Clinical supervision experience as supervisee	<ul style="list-style-type: none"> What was your supervision experience during your clinical practicum training? How would you describe the individual who was your best supervisor? Please describe your most challenging impactful moment as a supervisee within supervision during your clinical training 	<ul style="list-style-type: none"> Please elaborate? Tell me a little bit more about that. Earlier you mentioned... How did you feel when that happened? Please give me examples of what you mean? How did that experience affect you? What does/did that mean to you? How about...? (Babbie, 2013; McCandless & Eatough, 2012)
Clinical supervision experience as supervisor	<ul style="list-style-type: none"> Please describe your experience as a supervisor. Please describe your most positive impactful moment as a supervisor. 	<ul style="list-style-type: none"> Please elaborate? Tell me a little bit more about that. Earlier you mentioned... How did you feel when that happened? Please give me examples of what you mean? How did that experience affect you?

	<ul style="list-style-type: none"> ■ Please describe your most challenging impactful moment as a supervisor. What did you do to address the challenge? 	<ul style="list-style-type: none"> ■ What does/did that mean to you? ■ How about...?(Babbie, 1992, 2013; McCandless & Eatough, 2012)
Clinical supervision model	<ul style="list-style-type: none"> ■ How would you describe your approach to supervision? ■ Do you approach from a particular model or orientation? 	
Clinical supervisory process	<ul style="list-style-type: none"> ■ How do you describe the supervisory process? ■ How do you describe the relationship between supervisor and supervisee? ■ How do you describe your strengths as a supervisor? ■ How do you describe your challenges as a supervisor? 	<ul style="list-style-type: none"> ■ Please you elaborate? ■ Tell me a little bit more about that. ■ Earlier you mentioned... ■ How did you feel when that happened? ■ Please give me examples of what you mean? ■ How did that experience affect you? ■ What does/did that mean to you? <p>How about...?(Babbie, 1992, 2013; McCandless & Eatough, 2012)</p>
Clinical supervision method, techniques (Campbell, 2006; Bernard & Good Year 2014) and strategies	<ul style="list-style-type: none"> ■ What kind of techniques and strategies do you use? ■ How do you decide what to use and when? 	
Clinical supervision format, assignment, behavior and Challenges	<ul style="list-style-type: none"> ■ If you use more than one supervision format, is your supervisory process different in these formats? If so, how? ■ How do you decide what format to use? 	<ul style="list-style-type: none"> ■ Please you elaborate? ■ Tell me a little bit more about that. ■ Earlier you mentioned... ■ How did you feel when that happened?

	<ul style="list-style-type: none"> ▪ What do you usually focus on during the supervisory process? How do you describe the focus of supervisory process? ▪ What have you experienced as the differences between supervising first-semester and last-semester practicum students? ▪ What have you experienced in terms of challenges for supervisees? 	<ul style="list-style-type: none"> ▪ How did that experience affect you? ▪ What does/did that mean to you? <p>How about...?(Babbie, 1992, 2013; McCandless & Eatough, 2012)</p>
Culture awareness and sensitivity in clinical supervision	<ul style="list-style-type: none"> ▪ Do you use a different approach when supervising domestic supervisees and international supervisees? Why? And What are the differences? ▪ Was your supervisor culturally sensitive? 	<ul style="list-style-type: none"> ▪ Please you elaborate? ▪ Tell me a little bit more about that. ▪ Earlier you mentioned... ▪ How did you feel when that happened? ▪ Please give me examples of what you mean? ▪ How did that experience affect you? ▪ What does/did that mean to you? ▪ How about...?(Babbie, 1992, 2013; McCandless & Eatough, 2012)
Feedback for the interview	<ul style="list-style-type: none"> ▪ Do you have anything else you want to share about your experience supervising in the program that we didn't talk about during the interview? 	<ul style="list-style-type: none"> ▪ Please elaborate? ▪ Tell me a little bit more about that. ▪ Earlier you mentioned... ▪ How did you feel when that happened? ▪ Please give me examples of what you mean? ▪ How did that experience affect you? ▪ What does/did that mean to you? ▪ How about...?(Babbie, 1992, 2013; McCandless & Eatough, 2012)

After-interview statement:

Thank you for participating the interview with me today. Your answers and feedback are important to our study. It will help us to understand more about clinical supervision process from the perspective of a clinical supervisor. I will send the interpretations and the result of data analysis to you through email for you to confirm and approve the quoted will be used for the study.